Maternal and Child Health Services
Title V Block Grant

State Narrative for NEVADA

Application for 2007
Annual Report for 2005

Document Generation Date: Thursday, September 14, 2006

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Nevada's Assurances and Certifications are signed and filed in the office of the Chief of the Bureau of Family Health Services, Judith Wright. Ms. Wright serves as the MCH Chief for Nevada. This office is located at 3427 Goni Road, Suite 108, Carson City, NV 89706. Ms. Wright can be reached at jwright@nvhd.state.nv.us.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

Oportunity for public input on the 2007 MCH Block Grant application and 2005 Annual Report after required public notices was provided on July 7, 2006, at two sites. One hearing was held in Carson City, at the Legislative Council Bureau, and the other teleconferenced to Las Vegas at the state's Grant Sawyer office building at the same time. The Public Hearing was held on the same day and place as a meeting of the MCH Advisory Board. Written comments were solicited due July 10, 2006. Notice of preparation of the grant, the date and places of the public hearings, and an invitation for comment was published in newspapers on June 21, 2006 in Reno, Las Vegas and Elko and were sent to individuals on the Maternal and Child Health Advisory Board mailing list. Copies of the proposed grant were available by contacting the Bureau and the NEIS in Reno, Las Vegas and Elko. Copies were sent to members of the MCHAB and those who requested them. This application represents priorities established by the Year 2005 Needs Assessment including extensive public comment through the Needs Assessment process and the meetings of the MCHAB. Comments at the Carson City hearing noted the need for pediatric providers in the state. There were no written comments received.

Note: the 2005 CSHCN Needs Assessment is attached here as 2 documents couldn't be attached at the Needs Assessment Unit.
An attachment is included in this section.

II. Needs Assessment

In application year 2007, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

III. State Overview

A. Overview

There are many factors that impact the health delivery system in Nevada. The State Health Division seeks to improve the health and well being of all Nevadans through a myriad of programs and activities. In addition its priorities include building the public health infrastructure in the state, eliminating waiting lists for Early Intervention, and addressing bioterrorism. Within this context the Maternal and Child Health (MCH) program focuses on the well being of the MCH populations of women and infants, children and adolescents, and Children with Special Health Care Needs (CSHCN), and their families, addressing in particular those priorities identified in the MCH 2005 Needs Assessment. In Nevada, the MCH Title V Program is located in the Bureau of Family Health Services (Bureau) in the State Health Division. The Bureau serves as Nevada's MCH Agency.

Nevada's Maternal and Child Health Program is dedicated to improving the health of families, with emphasis on women, infants and children, including Children with Special Health Care Needs, by promoting, assuring and providing health education, prevention activities, quality assurance and health care services.

Nevada is a semi-arid, largely mountainous state with numerous valleys of primarily north-south orientation. The Sierra Mountains form a natural barrier on the west between Nevada and California. The Great Salt Lake Desert isolates eastern Nevada from the population centers of Utah. Approximately 83% of Nevada's land area is under the jurisdiction of the Bureau of Land Management; the remaining 17 % is under private ownership or state and local jurisdiction. Nevada has thirteen Indian colonies or reservations statewide and six military bases located in five counties. As in prior years, Nevada remains the fastest growing state in the nation. In the nine months after the 2000 census was completed Clark County in the south experienced a growth of 90,000, or 6.5% growth to a total population of approximately 1,500,000. According to Census Bureau estimates released April 8, 2004, for the 17th consecutive year Nevada remained the fastest growing state in the Nation. As predicted, most of the growth was in the south, with Clark County gaining more than 200,000 new residents. It is now number 17 on the list of largest U.S. counties, surpassing New York and Philadelphia. Rural Lyon County, in the north, ranked 15th as the fastest growing county per capita in the Nation, also according to Census Bureau figures. No end to Nevada's growth is in sight; the Nevada State Demographer projects Nevada's population will reach 2,442,116 in 2005. In 2004, the State Demographer has estimated Nevada's population reached 2,410,768. Clark County remains the largest in population, with an estimated 1,715,337 or 71% in 2004.

/2007/ Nevada continues to be the fasted growing state in the Nation. Per the State Demographer, Nevada reached an estimated 2,518,869 in population in 2005, a 4.5 percent increase and more than what was estimated. This is not as much as the 5 percent increase the year before, but still the fastest in the Nation. Per the U.S. Census Bureau figures, Nevada has been the nation's fastest growing state for 19 straight years. The largest increase was in Clark County (Las Vegas) which added 4.7 % or 81,000 people in 2005 for a total of 1,796,380. Washoe County (Reno) reached 396,844. Lyon County, over the hill from Carson City, is one of the fasted growing counties in the nation west of the Mississippi, showing a 9.4 percent growth to nearly 49,000. It will join Carson City and Elko as a Small Metropolitan Area (SMA) in 2006. //2007//

Nevada's 17 counties comprise an area of 110,540 square miles, making Nevada the seventh largest state in the Nation. Of Nevada's 17 counties, Clark and Washoe are considered urban with approximately 87% of the population; Carson City, Douglas, Elko, Lyon, and Storey counties are rural; and Churchill, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing and White Pine are frontier counties. It should be noted that Carson City and Elko have been designated a Small Metropolitan Area.

It is in this milieu that the following priorities for 2005 from the MCH Needs Assessment were established. They will guide the Bureau's work in the coming year:

1. Increase access to primary care services, providers, facilities, resources, and payor sources among the MCH populations.

2. Increase access to oral health services, providers, facilities, resources, and payor sources among the MCH populations.

3. Increase access to mental health services, providers, facilities, resources, and payor sources among the MCH populations.

4. Create a unified data system and surveillance system to monitor services delivered to the MCH populations.

5. Create "braided" services for CSHCN resources in Nevada including "one-stop-shopping" and "no-wrong-door" models of service delivery.

6. Increase financial coverage and decrease financial gaps for health services among the MCH populations.

7. Decrease the incidence of domestic violence among women of child-bearing age.

8. Decrease the risk factors associated with obesity for children and women.

9. Decrease unintentional injuries among the MCH populations. ***/2007/ no change //2007//***

As with every state, Nevada's MCH program is based on action taken by the biennial Legislature, which approves, sometimes with changes, the Governor's budget for allocating and appropriating funds and establishing their use. State agencies also establish performance measures and workload indicators to reflect the outcomes of their efforts in the coming biennium. In the 2003 Legislature there were two special sessions, which resulted in an increase in the tax base in the state which put it in better shape than in years past. For 2005, state agencies were instructed to construct their budgets for FY06 - FY07 at two times the expended general funds in the base year (FY04). The Bureau's budgets (MCH and WIC) followed this directive with the only changes in funding those to match what is expected in the various grants and fees that come to the Bureau. The change from the MCH Prenatal and Baby Your Baby programs discussed in prior Title V grant years to a Maternal and Child Health Campaign (discussed in III B) was recommended by the Governor and approved by the 2005 Legislature. Generally the Bureau's budgets for the upcoming biennium show no changes from the 2004-2005 biennium, with no gains and no losses. These budgets were closed (approved) on April 21, 2005. The Bureau's performance Measures, which are included in the budget, are as much as possible based on the findings of the MCH Needs Assessments. For 2006-2007 they include:

1. Percentage of infants born to women receiving prenatal care in the first trimester to promote healthy birth outcomes.

2. Nevada's teen birth rate (per 1,000) among 15-17 year old females.

3. Percent of newborns screened for metabolic disorders and hemoglobinopathies.

4. Percent of newborns screened for newborn hearing.

5. Number of SEARCH and National Health Services Corps primary care provider placements.

6. Percentage of WIC infants partially breastfed.

In addition to the fiscal situation there are many factors that impact the health services delivery system in the state. The extreme rurality of most of Nevada is one that leads to many challenges in developing a health services delivery system in the state. About 12% of Nevadans live in rural and frontier communities, most of which are remote (up to 250 plus miles) from urban centers. This is compounded by a lack of providers for both primary and specialty care that is even seen in the most urban communities. MCH supervises the Primary Care Development Center (PCDC), Nevada's Primary Care Organization (PCO). The PCDC is responsible for conducting the surveys necessary to establish Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs). HPSAs can be primary care, dental or mental health shortages and have a very high patient to provider ratio. These designations help with the recruitment of providers to underserved areas.

PCDC also manages the J-1 Visa program, which places foreign physicians in underserved areas. In FY03 the process for selecting J-1 Visa physicians was changed to give priority to those who serve in a Federally Qualified Health Center or Tribal Health Center, and to not approve any physicians who would be working at a non-primary care site. Currently, of Nevada's 17 counties, 10 in their entirety are Primary Care and Dental HPSAs, and 12 in their entirety are Mental HPSAs. With the exception of Carson City, the rest of the counties are partial HPSAs in all three designations. There are 24 HPSA designations and one MUP. ***/2007/ There are currently a total of 64 HPSAs, 31 for primary care, 17 for dental health and 16 for mental health. There are now 8 MUAs, 2 MUPs and 2 Governor's Designated Areas. The good news is that 3 areas no longer qualify for underserved status, those of Mesquite, portions of south central Las Vegas, and one in North Las Vegas. //2007//***

These designations help with the recruitment of providers to underserved communities through several programs that PCDC administers. In addition to the J-1 Visa Waiver program, PCDC administers the Student/Resident Experiences and Rotations in Community Health (SEARCH) training program for health care students, and the National Health Service Corps (NHSC). The J-1 Visa program, known as the Conrad 30 program, places foreign medical graduate physicians in medially underserved areas where it is often very difficult to recruit physicians. In FY 05 there are 76 (plus 7 pending) active J-1 physicians practicing throughout Nevada, 94 health care students that have received training through the SEARCH program, and 18 health care professionals that have been placed through the National Health Service Corps.

The PCDC works closely with the Primary Care Association (PCA), the Great Basin Primary Care Association (GBPCA), to promote the placement of health services personnel in underserved areas. It is working with GBPCA in implementing its Statewide Strategic Plan to develop at least 10 new primary care sites over the next five years. It is also working with GBPCA in several community development initiatives around primary care, the largest being in Las Vegas. PCDC also develops sites and places National Health Service Corp (NHSC) and SEARCH providers in clinical and pre-clinical rotations.

PCDC works closely with a number of key organizations involved in the development of primary care resources throughout the state. Included with GBPCA are Nevada Health Centers, Office of Rural Health, University of Nevada School of Medicine, Nevada Rural Hospital Partners, Area Health Education Centers, Washoe County Access to Health Care Network, and Clark County Health Access Consortium. In FY 05 the Washoe County Access to Health Care Network applied for and received for the first time in Nevada a CAP grant to promote access to primary care in Washoe County. This is the first CAP grant for Nevada. ***/2007/ With the ending of CAP funding the Washoe County Access to Health Care Network has pulled together to continue the activities started under the grant. //2007//***

Medicaid and the Child Health Insurance Program in Nevada:
Nevada's Medicaid and Children's Health Insurance Program are managed by the Division of Health Care Financing and Policy. The Nevada Division of Health Care Financing and Policy (DHCFP) contracts with two managed care organizations, which provide health care to Medicaid-eligible individuals in Clark County and urban Washoe County. Statewide enrollment in Title XIX Nevada Medicaid is approximately 166,000 and, as of June 2005, 81,861 of these recipients are enrolled in the managed care plans. Others receive care under Fee-for-Service Medicaid. Participants eligible for full Medicaid benefits pay no co-pays or premiums for covered medically necessary services, regardless of enrollment.

/2007/ The Nevada Division of Health Care Financing and Policy (DHCFP) contracts with two managed care organizations, which provide health care to Medicaid-eligible individuals in urban Clark County and Washoe Counties. Statewide enrollment in Title XIX Nevada Medicaid is approximately 172,479 and, as of May 2006, 80,110 of these recipients are enrolled in the managed care plans. Others receive care under Fee-for-Service Medicaid. Participants eligible for full Medicaid benefits pay no co-pays or premiums for covered medically necessary services, regardless of enrollment. //2007//

Nevada Check Up (the Title XXI State Children's Health Insurance Program) continues to grow as more eligible families learn about program availability. The program benefits children who are not eligible for traditional Medicaid and may not otherwise have access to health care. Currently, Nevada Check Up serves 28,836 children statewide. Of those, 23,715 are enrolled in the contracted managed care plans in Clark County and urban Washoe County. The remaining 5,121 children reside in rural counties and receive care under the Fee-for-Service program. There is no co-pay for covered medical benefits, although families do pay a monthly premium based on income and household size. The 2005 Legislature has assured there will be no cap on Nevada Check Up.

/2007/ In 2005 Nevada Check Up became a separate Bureau in DHCFP. Previously its management was combined with Medicaid Managed Care's.

The Nevada Check Up (the Title XXI State Children's Health Insurance Program) program benefits children who are not eligible for traditional Medicaid and may not otherwise have access to health care. Currently (July 2006), Nevada Check Up serves 27,542 children statewide. Of those, 23,221 are enrolled in the contracted managed care plans in Clark County and urban Washoe County. The remaining 4,321 children reside in rural counties and receive care under the Fee-for-Service program. There is no co-pay for covered medical benefits, although families do pay a quarterly premium based on income and household size.//2007//

Other Nevadans who are ineligible for traditional Medicaid but still need assistance obtaining health care may benefit from the recent passage of Assembly Bill 493 by the 2005 Legislature. The legislation allows the Division of Health Care Financing and Policy to apply to the Federal government for a waiver pursuant to the Health Insurance Flexibility and Accountability demonstration initiative. If authorized, the waiver will pave the way for Nevada to provide coverage for medical services or subsidies to three groups: 1) Pregnant women with household incomes between 133 and 185 percent of the Federal Poverty Level; 2) individuals employed by certain small businesses, whose incomes are below 200 percent of the FPL, and 3) low-income individuals who do not qualify for traditional Medicaid but who experience a health crisis that results in unpaid hospital charges exceeding $25,000. The Bureau works closely with the Division of Health Care Financing and Policy to ensure services needed by the MCH populations are provided.

/2007/ Nevada Assembly Bill 493, passed and approved by the governor in June of 2005 authorized the Division of Health Care Financing and Policy to apply to the Federal government for a waiver pursuant to the Health Insurance Flexibility and Accountability

demonstration initiative. The HIFA waiver was submitted to the Centers for Medicare and Medicaid Services in February of 2006. Language negotiations have pursued with expected approval in August. If authorized, the waiver will pave the way for Nevada to provide coverage for medical services or subsidies to two groups: 1) Pregnant women with household incomes between 133 and 185 percent of the Federal Poverty Level, and 2) individuals employed by certain small businesses, whose incomes are below 200 percent of the FPL. //2007//

Temporary Assistance for Needy Families (TANF) in Nevada:
Nevada's TANF Cash Grant program serves 8 population subgroups: Single Parents, 2-Parents, 2-Parents in which One or Both are Incapacitated, Non-Needy Caretakers, Kinship Care program, Non-Qualified Non-Citizens, SSI Households and Family Preservation Program ***/2007/ (FFP ended June 2005.)//2007//***. The last 5 of these categories are "child-only" programs in which only the children of the household are eligible for cash assistance.

In state fiscal year 2004, the average monthly number of Total TANF Cash Grants recipients was 24,956, of which 18,644 were children and 6,312 were adults. For state fiscal year 2005 year-to-date (through March 2005), the monthly average is 22,146, which is an 11.3% decrease from FY04. ***/2007/ In 2005 the caseload has decreased from a post-9/11/01 high of 35,122 recipients in May 2002 and is now almost at pre-9/11/01 levels. //2007//***

Although the continued improvement in Nevada's economy has contributed to the decrease in the TANF caseload since the impact of September 11, 2001, the largest factor has been the Welfare Division's development of strategies to ensure those applying for TANF cash assistance are committed to participating in self-sufficiency programs designed to train and connect recipients to employment.

As an example, under old business operations individuals approved for TANF were scheduled to attend orientation within thirty (30) days of approval to gain a full understanding of what was expected of them in pursuit of self-sufficiency. As a business process improvement, the orientation process was moved to pre-eligibility, allowing all TANF applicants the opportunity to learn what would be expected of them. Surprisingly, approximately 20% of TANF applicants withdraw their applications for cash.

Another business process change required all approved TANF recipients to report for thirty (30) hours of work assignments in the Welfare Office within seven calendar days after approval. When TANF recipients report to the Welfare Office they are assigned non-critical work activities such as paper shredding, photocopying, telephone answering, etc. More importantly, during the thirty hours Welfare Division staff have adequate opportunity to perform a full skills assessment, develop a comprehensive personal responsibility plan, fully address all Child Support issues, identify undisclosed client barriers and establish a long term self-sufficiency plan. ***/2007/ Per Welfare, this business process change ended almost as soon as it started. For the rest no change. //2007//***

Some newly approved recipients fail to complete this requirement and allow their case to be placed in sanction status. Once in sanction status clients are given thirty (30) days to secure program compliance or case closure will occur. When a case is placed in sanction status, the recipient is notified and all future TANF checks are placed in office pick-up status. When the TANF recipient comes to the office to pick up the check they meet with their case worker to address the non-compliance issue and develop a corrective action plan. ***/2007/ no change //2007//***

The aforementioned changes have significantly impacted the number of individuals participating in the TANF cash assistance program in FY04 and FY05 YTD.

The following are details about the individual TANF programs supplied by the Welfare Division:

a. AF - Single Parent Household. This is the typical case; usually a single mom & 2 kids. Payment for a 3 person household = $348.00 per month (p/m). Average family size = 2.83.
b. AI -- Two Parent Household (One or Both Incapacitated). This case will have an adult that is incapable of working due to a serious illness or injury. Payment for a 3 person household = $348.00 p/m. Average family size = 3.40.
c. UP -- Two Parent Household. This case has both adults not working but able to. Payment for a 3 person household = $348.00 p/m. Average family size = 4.34.
d. CON -- Child Only Non-Needy Caretaker Household. This is a case where adult relative(s) of the child(ren) are taking care of him/her/them. Payment for a 3 person household = $535.00 p/m. Average family size = 1.62.
e. COK -- Child Only Kinship Household. This case is similar to CON except that these are normally grandparents aged 62 and over and have court ordered custody of the children. Payments are per child. 0-12 years old receive $534.00 per child. Ages 13 and up receive $616.00 per child. Average family size = 1.65.
f. COA -- Child Only Non-Qualified Non-Citizen Household. This case is typically where the parent(s) are not in the country legally but have children that were born here. Payment for a 3 person household = $348.00 p/m . Average family size = 2.46.
g. COS -- Child Only SSI Household. This case has a parent(s) that is eligible for SSI payments. Payment for a 3 person household = $348.00 p/m . Average family size = 2.05.
h. COF -- Child Only Family Preservation Plan Household. This is a case where a severely handicapped child is kept at home instead of being institutionalized. Payments are per child. Any age = $350.00 per child. Average family size = 1.00. This program is scheduled to be transferred to the Mental Health Division effective 01 July 2005 (SFY06 start). ***/2007/ This program was transferred as planned to Mental Health/Developmental Services Division July 1, 2005. //2007//***

Prior to July 2004 the Kinship program only paid an additional $100.00 per additional child. This was changed starting with July 2004 for a larger payment as stated above.

Average family sizes quoted above are FY2005 year to date.

/2007/ The following are the details for 2005 and 2006 year to date:

a. AF - Single Parent Household. Average family size = 2. 78.
b. AI -- Two Parent Household (One or Both Incapacitated). Average family size = 3. 48.
c. UP -- Two Parent Household. Average family size = 4. 29.
d. CON -- Child Only Non-Needy Caretaker Household. Average family size = 1. 65.
e. COK -- Child Only Kinship Household. Average family size = 1. 62.
f. COA -- Child Only Non-Qualified Non-Citizen Household. Average family size = 2.460.
g. COS -- Child Only SSI Household. Average family size = 1.98.

Average family sizes quoted here for FY2006 year to date.

There have been no changes in the description of the programs or the amount of the cash grants. //2007//

B. Agency Capacity

The Bureau works to leverage its resources to promote and protect the health of the MCH populations it serves including CSHCN. It does this through partnering and collaborating with a

myriad of agencies and programs, both government and private, across the state. Many of those efforts are described in this Section.

Program authority for Nevada's MCH and CSHCN programs are contained in Nevada Revised Statutes (NRS) and Nevada Administrative Codes (NAC) as follows:
* NRS 442.120-170, inclusive. Designates the department of human resources through the health division to "Cooperate with the duly constituted federal authorities in the administration of those parts of the Social Security Act which relate to maternal and child health services and the care and treatment of children with special health care needs".
* NRS 442.130. Designates DHR as the agency of the state to administer, through the SHD, a MCH program, and to advise the administration of those services included in the program that are not directly administered by it. "The purpose of such a program shall be to develop, extend and improve health services, and to provide for the development of demonstration services in needy areas for mothers and children".
* NRS 442.133. Establishes the Maternal and Child Health Advisory Board. The purpose of the Board is to advise the Administrator of the SHD concerning perinatal care to enhance the survivability and health of infants and mothers, and concerning programs to improve the health of children.
* NRS 442.140. Authorizes a state plan for MCH.
* NRS 442.180-230. Authorizes the department (DHR) to "administer a program of service for children who have special health care needs or who suffering from conditions which lead to a handicap, and to supervise the administration of those services included in the program which are not administered directly by it."
* NRS 442.190. Authorizes a state plan for children with special health care needs.
* NRS 442.115. Authorizes the State Board of Health (also appointed by the Governor) to adopt regulations governing "examinations for the discovery of preventable inheritable disorders, including tests for the presence of sickle cell anemia". The follow-up for those whose examinations and tests "reveal the existence of such a condition" is described in this statute also. The newborn screening program is placed in the Bureau.
* NRS 442.320-330. Authorizes the establishment of a Birth Defects Registry
* NAC 442. Maternal and Child Health. Establishes regulations for the CSHCN program regarding eligibility, covered conditions and so forth. It establishes the protocol for the taking of blood samples from infants for newborn screening, establishes fees for services of the Bureau of Early Intervention Services' Early Intervention Services, and the nurses of the Bureau of Community Health Services, and defines level of care of hospital neonatal units. It also establishes the provisions for the operation of the Bureau's Birth Defect Registry.

Note: The 2005 Legislature changed the name of the Department of Human Resources to the Department of Health and Human Services. This change will occur in the coming year. For the purposes of this document, DHR will be used when referring to the Department.

All of the above statutes and regulations impact the operations of Nevada's MCH and CSHCN programs by giving state authority for the programs to the SHD and setting operating regulations into state law. This ensures the programs operate within legal boundaries established and monitored by the state. In addition to the authority for MCH, CSHCN, Newborn Screening and the Birth Defects Registry contained in NRS and NAC, the state budget process also places MCHB's Abstinence Education, SSDI, and Newborn Hearing grants, WIC, Primary Care Organization, the Center for Disease Control and Prevention's (CDC's) Oral Health, Rape Prevention and Injury Prevention grants and the Centers for Medicare and Medicaid Real Choice Systems Change grant within Bureau operations. In FY04 the MCHB funded Early Childhood Comprehensive Systems grant was added.

The Bureau seeks to work closely with state's public health community including the Clark County Health District (CCHD), Washoe County District Health Department (WCDHD) and Carson City Health Department to promote the health and well being of the MCH/CSHCN populations in those counties, as well as with the other Bureaus of the SHD. Title V funding supports adolescent

health clinics in both Clark and Washoe Counties. Title V funding provides some support for Community Health Nursing in Nevada's rural and frontier counties.

The Bureau is home of a small program that is payor of last resort for the treatment of CSHCN. This program acts as a safety-net provider for eligible individuals who do not meet the eligibility requirements for Medicaid, Supplemental Security Income (SSI which includes Medicaid in Nevada), or Nevada Check Up (Nevada's S-CHIP program), and otherwise meet the eligibility requirements contained in NAC. For covered children the program will pay for specialty and subspecialty care, nutrition and primary care and reconstructive dental care if the child does not have insurance. CSHCN staff refer potential eligible families to Medicaid, SSI, and Nevada Check Up, and follow them until eligibility determination has been made. The Health Division data system has been revised and converted to new software that allows automated data matches with Newborn Screening, the Birth Defects Registry, Medicaid claims, Vital Statistics and Newborn Hearing Screening, and a variety of other state programs. This enables staff to better track what programs and/or initiatives are following the children, services received, etc. The monitoring of eligibility of children referred to Medicaid and Nevada Check Up is now accomplished on-line. Eligibility for the program is currently established at 250% of the Federal Poverty Level, with legal residency in the Nation and Nevada residency required.

The Bureau used to have a program that paid for prenatal care for eligible women. This was discontinued in May of 2004. The Bureau now promotes obstetrical services for low-income, high-risk women through a program called the Maternal and Child Health (MCH) Campaign. The Bureau currently has a contract with a community-based provider in Las Vegas, which serves primarily Hispanic and African American clients. In FY 06 it will have a contract with a community based provider in Reno in addition to the one in Las Vegas. Besides prenatal care, each client is screened for social service needs, nutrition needs, domestic violence, substance abuse, and perinatal depression. These community, direct-service providers will screen all clients for social service, referring to various community agencies as needed, in addition to providing obstetrical services. Early entry into prenatal care is particularly low among Hispanic women. All contracted agencies with the Bureau are to offer bilingual (English and Spanish) service, and have culturally appropriate materials. As part of the services provided by the community based provider the infant born to the covered mother is followed to age one. A medical home will be established for the infant when this service ends on their first birthday.

Another part of the MCH Campaign is a toll free bilingual (English and Spanish) Information and Referral Line (IRL) that serves as a referral source for pregnancy care statewide. It is also provides information for families in need of pediatric care, with referrals to Nevada Check Up, Medicaid, and pediatric providers a service offered through the IRL. Campaign pediatric providers are in Clark and Washoe Counties, and in the rural communities of Armagosa, Austin, Beatty, Elko, Eureka, Gerlach, Hawthorne, Pahrump and Carson City. This number is 1-800-429-2669 (the same number used for Baby Your Baby). The IRL has been a primary component for signing up women, infants and children for Medicaid and Nevada Check Up as well as referring them and their families to other services such as WIC, immunizations, adoption, substance abuse treatment, a source for dental care, etc. All who call are queried regarding their insurance status. If they do not have or have concerns about it, staff will refer them to Medicaid and/or Nevada Check Up and other resources such as the members of GBPCA and the Bureau's MCH Campaign providers and CSHCN program. A third part of the MCH Campaign is an outreach campaign that includes a mass-media campaign, again in both English and Spanish, that educates the public about pregnancy and other related matters. The Bureau has contracted with the Nevada Broadcaster's Association to air both radio and television announcements about the importance of early and continuous prenatal care, information about Medicaid and Nevada Check Up, proper nutrition during pregnancy, and where care may be obtained. This outreach campaign is funded by a contract with DHCFP, Medicaid. For each dollar that the Bureau spends on public education, Medicaid will match it.

The Bureau also now has a toll-free IRL for CSHCN. This new phone number is currently being

marketed through a media campaign. It refers callers to services available in the state for CSHCN and their families. This number is 1-866-254-3964.

The Bureau is linked electronically with Medicaid and Nevada Check Up eligibility records in order to check eligibility and prevent duplications. The CSHCN Program does not serve those eligible for Medicaid or Nevada Check Up (unless it is a service such as specialty foods that Medicaid or Nevada Check Up do not pay for). This is possible through NRS, which allows sharing of information between Divisions of the Department of Human Resources and ensures confidentiality of those communications.

The Bureau has a web page where a description of Bureau programs and initiatives may be found and links to web pages either specific to the Bureau such as Oral Health and WIC or relative to MCH such as the Interactive Data Base of the Center for Health Data and Research that is partially supported by the SSDI grant. The Bureau web page is located at http://health2k.state.nv.us/bfhs/. Program web pages can be accessed through the Bureau's main web page. The Prenatal web page contains information on how to have a healthy pregnancy, infant care, well child issues, teen pregnancy issues, and many other topics related to maternal and child health. It is one of the most popular web pages on the SHD web-page, receiving several hundred hits a week. A new CSHCN web page was launched in January 2005. It contains links to Medicaid, Nevada Check Up, Food Stamps, SSI, and other programs that might be useful for CSHCN and their families. It is currently being marketed through a media campaign.

The Bureau continually works to partner with Medicaid in promoting the health and well-being of Medicaid pregnant women and then their infants. Through contacts between the two agencies and interaction before the Maternal and Child Health Advisory Board (MCHAB) MCH is able to bring concerns about both Medicaid and Nevada Check Up to the attention of the regulatory agency and see them addressed as much as possible. The Bureau continues to look for ways to perform outreach for Nevada Check Up and Medicaid including the contract for the MCH Campaign. Referrals to Nevada Check Up and Medicaid are made through the CSHCN Program, the MCH campaign and WIC, and in FY 06 through the Real Choice Systems Change pilot projects discussed below.

The Bureau continues to work closely with the University of Nevada School of Medicine (UNSOM). Bureau staff contract with some and otherwise support UNSOM participation in multi-disciplinary clinics for CSHCN that include Genetics, and Cleft/Craniofacial clinics in Reno and Las Vegas. The Bureau Chief and a UNSOM Geneticist are currently working out the details of a Fetal Alcohol Syndrome multi-disciplinary clinic that will first be held in Las Vegas. A vision care clinic also in Las Vegas at a Early Intervention site has recently been proposed and is under consideration.

The Bureau is working very closely with the new Office of Disability Services and Community Based Services which are in DHR Director's office. The Office of Disability Services is working closely with the Real Choice Systems Change project discussed below, particularly on the area of transition of CSHCN to adulthood. It was also the lead on a "211" line for one-stop referrals proposed during the current legislative session and worked with the Bureau to ensure the Bureau's hot lines were appropriately included. This bill did not make it out of session; it was however reintroduced in an omnibus bill that included $200,000 to implement a 211 line. A committee of representatives from the various DHR Divisions including Health's MCH is currently meeting to begin the development of the line.

The Department of Human Resources is the recipient of a three-year Centers for Medicare and Medicaid Services (CMS) $1,385,000 grant to build systems of care for Children with Special Health Care Needs. This is a "Real Choice Systems Change" (RCSC) grant. This DHR grant was placed in the Bureau for implementation. It experienced a delay in implementation which will lead to a fourth year into FFY 06. Its components are a CSHCN Advisory Committee, a CSHCN Needs Assessment, a web page, and 3 pilot projects implementing the findings of the Needs

Assessment for CSHCN systems development. The media campaign is currently underway (and is the one marketing the CSHCN web site and IRL.) The Needs Assessment was completed in January 2005 and the Advisory Committee appointed; several meetings have been held. The Advisory Committee has had a subsequent meeting to review the findings of the Needs Assessment and is overseeing the pilot projects that the grant calls for based on the findings of the Needs Assessment. The CSHCN Needs Assessment is a complete in-depth assessment of CSHCN in Nevada to provide a better understanding of the nature and magnitude of challenges facing CSHCN ages birth to 22 and their families in Nevada (e.g., the level of need, amount of services available, amount of services required, service gaps, cultural issues, service duplications, etc.). The data generated by this study will help address CSHCN systems development. Three pilot projects, northern urban, southern urban, and rural, are in the process of being developed and implemented based on the findings of the Needs Assessment. The data generated from the needs assessment will also be used to develop public policy initiatives and demonstration projects to ensure coordinated, family-focused, and community-integrated systems of care for all of Nevada's Children with Special Health Care Needs. This includes family partnership in system planning and service selection, effective supports for CSHCN transitioning to adult life, and better-coordinated care throughout childhood and into young adulthood. This is the piece that is being coordinated with the Office of Disability Services.

The PCDC partners very closely with the Great Basin Primary Care Association and its members to promote access to primary care for all Nevadans including pregnant women, infants, children and adolescents, and CSHCN. In many rural parts of the state as well as in Washoe and Clark Counties GBPCA members are the only providers available for primary care including infant well-child and other care particularly for low income individuals. In 2005 one of its members, Nevada Health Centers, also became a WIC provider in Southern Nevada. In addition, the MCH supported Community Health Nurses of the BCH provide well-child services for infants in the rural counties.

MCH will continue to support Adolescent Clinics in Reno and Las Vegas. These are provided under contract with Washoe County District Health Department (WCDHD) and the Huntridge Teen Clinic in Las Vegas. The Child and Adolescent Health Coordinator will work with the Adolescent Clinics in the coming year to assure they continue to address identified needs. For FY06 the contract in Washoe County was out to bid in FY 05 and will stay with WCDHD. The Huntridge Teen Clinic in Las Vegas was bid this year (2005) and stayed with the same contractor.

The MCH Chief serves on DHR's Child Care Advisory Committee, representing the SHD to promote health concerns. The Child Care Steering Committee includes representatives of Health, Welfare, Dept. of Education, Nevada's Community Colleges, University of Nevada, Head Start, Welfare contractors, Consumers, Family to Family Connection, etc. It is charged with advising the Department of Human Resources and the Governor on improving quality and availability of child care for Nevada's children, particularly those services provided to TANF recipients and clients who are receiving transition services from TANF. The MCH Chief is one of 4 state employees on this Committee.

The MCH Chief participates in the Title V-B Steering committee for Family Preservation and Support. The MCH Chief will continue work to ensure MCH concerns are addressed in any changes to Nevada's Title IV-B program. Through the DHR Child Care Advisory Committee, the MCH Chief continues to promote the inclusion of training for care of CSHCN in all training initiatives. The inclusion of CSHCN in all publicly funded child care including those sites receiving assistance with development and training from Welfare is also promoted.

The Bureau continues to work with the Welfare Division for the training of Child Health Care Consultants. The federal grant supporting this initiative which was held by the University of Nevada Reno has ended. In 2006 the initiative will be continued in rural counties by the Community Health Nurses of the BCH, and in Washoe County with support from child care dollars from Welfare. The Bureau has become the lead agency for this initiative in the process.

Nevada Revised Statutes state that all child care providers must attend a class that covers preventing and recognizing illnesses. In the past, this class has been held only in Clark and Washoe Counties on a regular basis, and Bureau personnel have given the class when possible in the rural counties and parts of Clark County. Most child care providers have not been able to receive this class due to access issues. However, now all community health nurses in the rural counties have been trained by Bureau personnel to teach the "Prevention and Recognition of Illnesses in the Child Care Setting" class. In addition, Southern Nevada Area Health Education Center (AHEC) personnel located in Clark County are being taught the curriculum so that they can service the outlying areas of Clark County. In the near future, this class will be available state-wide and all child care providers should be able to access this class easily.

The 2005 Legislature approved the establishment of an Office of Minority Health effective July 1, 2005, in the DHR Director's office. This has been a goal of the Department for many years. The purposes of the Office are to improve the quality health care services for members of minority groups; increase access to health care services for members of minority groups; and disseminate information to and educate the public on matters concerning health care issues of interest to minority groups. The Bureau will partner with the new office to address minority health and health disparities in all its efforts.

The Bureau works with all known parent and advocacy groups such as Parents Encouraging Parents (PEP), Family Voices, "Nevada Partners in Policymaking" and the "Nevada Dual Sensory Impairment Project", to discuss available programs and accessing services within the community. Activities have included meetings and panel discussions with consumers in both Reno and Las Vegas to discuss the scope of services covered by Title V programs, as well as developing linkages with other agencies such as Medicaid, Nevada Check Up, Vocational Rehabilitation, Shriner's, and the Department of Education, for access to, and coordination of, services. The meetings included a cross section of consumers, many of whom are adults with disabilities, as well as the parents and foster parents, of children who have a variety of disabilities and needs. This also provided an opportunity to dialog with members of the community and the staff of multiple community agencies. As a result, there is increased communication within a growing network of service organizations and consumers. Family Voices was very prominent in assuring parents of CSHCN input into the MCH Needs Assessment, and will assist with implementing its findings. The CSHCN program now includes information about Family Voices in all its communications with families. All of these agencies and consumers are involved in the development of the Real Systems Change initiative. The Family Voices Director is developing the RCSC media campaign.

/2007/ There has been no change to NRS and NAC since last year or to the information reported above. The Department of Human Resource officially has become the Department of Health and Human Services (DHHS).

The Fetal Alcohol Syndrome multidisciplinary clinic has been developed in partnership with the UNSOM, and is currently being held in Las Vegas. Funds are being sought to hold a similar clinic in Reno. The vision care clinic went on hold when the staff proposing it quit. It is now being revisited by staff to see if the resources are still there and if new partners that have since been identified are able to help.

The 211 line was officially kicked off on February 9, 2006 and in service February 13, 2006. It is not yet statewide. Currently it is available to the metropolitan areas of Washoe County, Carson City, and most of Clark County. Ultimately it will be available statewide. Statewide cellular access to 211 will be available to certain cellular subscribers initially and will become available through other cellular providers as capabilities and service areas are expanded. Unfortunately there are pockets all over rural Nevada where there is no cellular service. Until 211 is fully implemented 1-800 lines such as the Bureau's CSHCN information and referral and line will continue to operate so those who do not have access

to 211 can still call toll free for services.

The DHHS Title IV-B Family Preservation and Support Steering Committee is no longer meeting. Its activities have been absorbed by other activities going on in the state including the Child Death Review initiative discussed in IV A Background and Overview.

The DHHS Child Care Committee has not met.

The Office of Minority Health has been established; it is based in Las Vegas. The Bureau's Bureau Chief has been in contact with the new Minority Health Director and enlisted his assistance in the expansion of the MCH Campaign to address African American birth outcomes discussed in the Annual Plan for National Performance Measures (NPM) 15, 17 and 18 and State Performance Measure (SPM) 11. He is building support in the Las Vegas African American community for this enhancement, which will be presented to the 2007 Legislature.

The CSHCN program's eligibility line was transformed into a statewide toll-free CSHCN helpline offering assistance to more families than before. The Health Program Manager from the grant project will continue work for the Bureau of Family Health Services (Title V) programs. Community-based service providers affiliated with the grant project may be considered for contract work.

There has been an attempt to include more bi-lingual members on the Nevada Advisory Council for CSHCN and producing outreach materials in English and Spanish. The website translation is in a pending status (rudimentary translation available, improved translation in the works). The Native American temporary worker who has been successful with Native American outreach has future Maternal and Child Health funding.

The RCSC Project has segued into a CSHCN systems development project that will combine all the CSHCN systems development efforts under one umbrella. This project is now under an overall CSHCN Coordinator who will manage it and the specialty clinics, BDR, newborn screening, newborn hearing screening, and any other components of the CSHCN system. Through the systems development activities a training for those with potential responsibility for utilization of EPSDT screening will be offered in the fall of 2006. //2007//

An attachment is included in this section.

C. Organizational Structure

Nevada's Executive Government is set up with the elected Governor as the Head of State. The current Governor is Kenny Guinn, now in his second four-year term, which expires in January 2007. Under the Governor are the various Departments that along with Boards and Commissions that make up the Executive Branch, including Human Resources, Employment, Rehabilitation and Training, Information Technology, Motor Vehicles, Public Safety, Conservation and Natural Resources, Cultural Affairs, Administration, Personnel, Agriculture, and Business and Industry. The Legislative Branch includes the Senate and Assembly, the Legislative Counsel Bureau and Legislative Committees. The Judicial Branch includes the court system, commissions and the State Board of Pardons. An org chart of Nevada State Government may be found at http://www.leg.state.nv.us/lcb/research/StateOrgChart.pdf.

The state public health agency, the State Health Division (SHD), is in the Department of Human Resources (DHR). DHR also includes the state mental health agency, the Division of Mental Health/Developmental Services(MH/DS); the social services/child welfare agency, the Division of

Child and Family Services; Aging; the Medicaid and Nevada Check Up agency, the Division of Health Care Financing and Policy(DHCFP); and the TANF and Child Care Block Grant agency, Welfare. Mike Willden is the Director of DHR. The org chart for DHR may be found at http://hr.state.nv.us/Documents/DHR_904.pdf. The Bureau works closely with all the Divisions of DHR to promote MCH priorities and objectives. ***/2007/ As previously noted DHR is now the Department of Health and Human Services, DHHS. //2007//***

As noted in III.B, Agency Capacity, Nevada Revised Statute 442 designates the Department of Human Resources through the State Health Division to administer those parts of the Social Security Act which relate to Maternal and Child Health and the care and treatment of Children with Special Health Care Needs. Within the SHD the MCH and CSHCN programs are in the Bureau of Family Health Services.

The SHD contains 7 Bureaus all headed by a Bureau Chief. In addition to the Bureau of Family Health Services they include Community Health (BCH), Licensure and Certification (BLC), Health Planning and Vital Statistics (BHP&VS), Early Intervention Services (BEIS), Health Protection Services (BHS), and Alcohol and Drug Abuse (BADA). Alex Haartz, MPH, is the Administrator of the SHD. Mr. Haartz received his MPH from Tulane University. Prior to coming to the SHD he was with the San Diego County Department of Health providing public health education. He began his career with the SHD with the Bureau, and is an advocate for MCH. The State Health Officer is Dr. Bradford Lee. Dr. Lee came to the SHD from the United States Air Force, where he served for more than 29 years. His medical degree is from Howard University, College of Medicine; his Juris Doctorate is from the University of the Pacific McGeorge School of Law. The SHD organization chart is attached at III B, Agency Capacity.

The Bureau works very closely with all six of the other Bureaus. It provides funding for Community Health Nurses in BCH and partners with BCH on chronic disease initiatives. The Center for Health Data and Research in the BHP&VS works with the SSDI grant and produces the data for the MCH Block Grant application and oversees the MCH Needs Assessment process. BADA works with the Bureau on its Perinatal Substance Abuse Prevention initiative, particularly focusing on adolescents. A bill in the 2005 Legislature will move BADA to MH/DS; even should this move occur the Bureau and BADA will continue to collaborate. While the Bureau's Oral Health Unit has the fluoride initiative, BHP has the engineers that monitor the water systems. The Bureau works with BLC on emergency medical services and on Newborn Intensive Care Unit regulations, which they regulate. Finally, the BEIS is collocated with the Bureau and works closely with the CSHCN program and other Bureau initiatives. Title V funds support the BEIS services. The Bureau also supports the multi-disciplinary specialty clinics held in BEIS facilities. The Bureau org chart is attached.

The Bureau of Family Health Services under the SHD Administration is responsible for Title V MCH Block Grant oversight, management and reporting. The Bureau has many programs and initiatives that all go to promote the health and well being of Nevada's families. Judith Wright is the Bureau Chief and MCH Director.

Nevada's MCH Program is advised by a Maternal and Child Health Advisory Board (MCHAB). The MCHAB was first established through an executive order in 1989, and then was established in statute in 1991 by NRS 442.133. It is comprised of 9 individuals appointed by the Governor from a list provided by the SHD Administrator to two year terms, and two legislators appointed by the Legislative Counsel. Its composition represents public health, providers, legislators and a consumer who always represents CSHCN. Per NRS the MCHAB is advisory to the Administrator of the SHD. They meet 4 to 6 times a year, alternating between Reno and Las Vegas, and more frequently now by videoconference. They respond quickly to issues as they come up and have testified before the Legislature on bills of concern to the Department. They produce a bi-annual report includes a report of their activities for the biennium and recommendations for the coming biennium. This report is placed on the Bureau's web page and some hard copies distributed at the Legislature. The 2005 report is attached to I.E, Public Input, as is noted there. The MCHAB

is staffed by the MCH Bureau Chief. Under NRS they are charged to advise the Administration of the SHD "concerning perinatal care to enhance the survivability and health of infants and mothers, and concerning programs to improve the health of preschool children to achieve the following objectives:

1. Ensuring the availability and accessibility of primary care health services;

2. Reducing the rate of infant mortality;

3. Reducing the incidence of preventable diseases and handicapping conditions among children;

4. Identifying the most effective methods of preventing fetal alcohol syndrome and collecting information relating to the incidence of fetal alcohol syndrome in this state;

5. Preventing the consumption of alcohol by women during pregnancy;

6. Reducing the need for inpatient and long-term care services;

7. Increasing the number of children who are appropriately immunized against disease;

8. Increasing the number of children from low-income families who are receiving assessments of their health;

9. Ensuring that services to follow-up assessments are available, accessible and affordable to children identified as in need of those services; and

10. Assisting the Health Division in developing a program of public education that is required pursuant to NRS 442.385, including, without limitation, preparing and obtaining information relating to fetal alcohol syndrome (FAS);

11. Assisting the University of Nevada School of Medicine in reviewing, amending and distributing (FAS) guidelines it is required to develop pursuant to NRS 442.390; and

12. Promoting the health of infants and mothers by ensuring the availability and accessibility of affordable perinatal services."

The Bureau is also advised, as are other agencies in state government, by the Governor's Youth Advisory Council (GYAC). The GYAC was originally established by Governor Robert Miller in 1995 by executive order and has been continued by Governor Guinn. The GYAC is comprised of 11 youth ages 15 - 21 from statewide, of mixed ethnicities and race. They are staffed by the Bureau's Child and Adolescent Health Manager. For 2006, the GYAC has established as its priorities teen pregnancy prevention, violence prevention, and suicide.

The State Board of Health (SBOH) is a regulatory body that is staffed by the SHD Administrator. As MCH is not regulatory it does not have much activity before the SBOH, but it does go before them to set fees for Newborn Screening and other matters that are contained in the NRS for the Bureau. The Newborn Screening fee increase was approved by the SBOH in September 2003. In 2004 the Bureau partnered with BLC to update the NICU regulations, which were approved by the SBOH on June 25, 2004.

The CSHCN Program has already been described in III.B. Agency Capacity. It pays for treatment for eligible children. The CSHCN program includes Newborn Screening, Newborn Hearing Screening, and the Birth Defects Registry. These three programs are all required by NRS. The Newborn Screening and Birth Defects Registry programs and the program's supervisor are funded by newborn screening fee revenue. Newborn Hearing is funded by HRSA (this grant will end in 2006 and another has recently been approved). CSHCN also includes the Real Choice

Systems Change Grant that is funded by CMS.

The MCH Perinatal and Women's Health program includes the Perinatal Substance Abuse Prevention (PSAP)program, the MCH Campaign, and Domestic Violence, Injury and Rape Prevention programs. Injury and Rape Prevention are funded by CDC. PSAP is funded by state general fund. The supervisor of the unit is funded by Title V, the MCH Block Grant.

The MCH Perinatal and Women's Health and CSHCN Programs are headed by Health Program Specialist IIs.

The Child and Adolescent Health Program addresses teen pregnancy prevention and other initiatives to promote the health and well-being of Nevada's children and adolescents. It includes the Abstinence Only grant now managed by the Administration for Children and Families. It also includes the MCHB Early Childhood Systems Development grant, and with the additional funding from the MCH Block Grant the state received has a component for Early Childhood systems development for ages 6-10. It is headed by a Health Program Specialist II who is funded by Title V, the MCH Block Grant.

The Oral Health Unit includes a statewide sealant initiative, a fluoride initiative, Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A.), Early Childhood Caries prevention, Oral Health Surveillance, and is developing an oral health curriculum for primary and secondary education. It is funded by CDC and MCH Block Grant. The Oral Health Unit is headed by a Health Program Specialist II who is funded by the CDC grant.

The WIC Program has clinics statewide. It is currently serving approximately 46,000 participants a month. It is funded by USDA and rebates. It is headed by a Health Program Manager II who is funded by the WIC grant. WIC expects to reach 60,000 by the end of the next biennium (FY2006-FY2007.

The Primary Care Development Center works to promote access to primary care statewide. It has the Primary Care grant from the Bureau of Primary Health Care, SEARCH from the Bureau of Health Professions and the HRSA/MCHB funded SSDI program. It is headed by a Health Resource Analyst III who is funded by the Primary Care grant.

Specific staff of the Bureau are listed in III D. Other (MCH) Capacity.

Title V funding is also placed as previously mentioned in the Community Health Nursing budget and in Early Intervention Services. Both programs work with the Bureau and provide the reporting required by the block grant. The MCH Bureau Chief assures the funding is being spent in accordance with federal regulation.

/2007/ There will be an election for Governor in November 2006. What effect this election will have on the Bureau's budget and activities remain unknown at this time. Under the current Governor, Governor Guinn, the Bureau has received permission to develop budget enhancements to increase the MCH Campaign and address resources to teen pregnancy prevention. These enhancements are discussed in the Annual Plan. Otherwise budget development instructions are as there were last session, that is two times the base year 2005 for total general fund for the 2008-2009 biennium.

As proposed in the 2005 session, BADA is moving to the Mental Health/Developmental Services Division effective July 1, 2007. As noted last year the Bureau and BADA will continue to collaborate around the issues such as perinatal substance abuse prevention but it will now be across Division lines.

Safe Drinking Water was moved from BHP to the Department of Conservation and Natural

Resources (DCNR). The Bureau's Oral Health Program is now working with those engineers in monitoring water systems for fluoride.

The CSHCN Program has the CSHCN Advisory Committee as discussed in III B. This Committee, comprised of parents, advocates and providers, advised on the development of services for CSHCN that are community based, family centered, culturally appropriate and comprehensive. They are advisory to the Administrator of the Health Division. //2007//

An attachment is included in this section.

D. Other MCH Capacity

Nevada's MCH/CSHCN programs, located in the Bureau, are managed through its main office in Carson City, Nevada. Staff who are located in the Carson City and Las Vegas offices are listed in the attached table along with CVs of program managers.

Judith Wright, Bureau Chief, is a graduate of the University of Chicago, Chicago, IL. She has been in Public Health since 1978, and MCH specifically since 1989, having formerly served as a WIC Administrative Officer and then CSHCN Director in Montana. She came to Nevada to become Bureau Chief in September 1994. She directly supervises an Administrative Assistant IV, an Accounting Assistant III, and the Bureau's Administrative Services Officer I. She also supervises the managers of CSHCN, the CSHCN Registered Dietitian, Women's Health/Perinatal, PCDC, WIC, Oral Health, Child and Adolescent, and Real Choice Systems Change (RCSC). There is also a bilingual Administrative Assistant I assigned to the Bureau overall. The Administrative Assistant IV supervises all the clerical staff in the Bureau with the exception of those in PCDC. ***/2007/ With the Bureau reorganization the CSHCN and the initiatives of the RCSC will go under the CSHCN Coordinator. The Bureau Chief will supervise the now MCH Funded Management Analyst 2 to provide the start of a MCH EPI unit. This will address Priority 4 and SPM 4 (regarding a unified data and surveillance system). //2007//***

Gloria Deyhle, RN, Health Program Manager II, CSHCN Manager, got her nursing degree from Mount Sinai Hospital School of Nursing. She has been CSHCN Manager since 1990, having previously worked as a Medicaid Services Specialist in the Welfare Division. The CSHCN Program staff also includes a contractor for newborn hearing (the grant ends in 2006), a Health Program Specialist I for the Birth Defects Registry, one Family Service Specialist II and an Administrative Assistant I for the payment portion of the program. ***/2007/ Gloria retired June 2, 2006. At this time the position of CSHCN Manager is vacant. It will be the supervisor of the entire CSHCN program including those efforts formerly funded by CMS through the RCSC project. The newborn hearing screening position is currently vacant; it will be revisited in the new fiscal year when the new grant is received. //2007//***

Cynthia Huth, CNM, Health Program Specialist II, Women's Health/Perinatal Coordinator, received her MS in Nursing/Midwifery from the University of Utah. She was a practicing midwife until 1996 when she came to work for the Bureau as a Perinatal Nurse Consultant. This unit includes two Health Program Specialist Is for Perinatal Substance Abuse Prevention and Injury/Rape Prevention. There is one contractor ***/2007/ FTE //2007//*** bilingual Administrative Assistant I assigned to this program for the MCH Campaign and a .5 FTE Administrative Assistant I for Injury Prevention. ***/2007/ This position will become the medical consultant to the Bureau when the Bureau is reorganized. //2007//***

Mark Hemmings, Health Resource Analyst III, PCDC Manager, received his Masters from Central Michigan University (Extension), Honolulu, Hawaii. Before becoming manager of the PCDC in

2002 he was a Health Resource Analyst in the Bureau of Health Planning and Statistics. PCDC includes a Health Resource Analyst I for SEARCH, a Health Resource Analyst II for NHSC, a Health Resource Analyst II for SSDI, and 1.5 Administrative Assistants Is. ***/2007/ There is 1 FTE Administrative Assistant in PCDC now. //2007//***

Steve Kepp, Administrative Services Officer I, received his MBA from Nova Southeastern University in Florida. Before coming to the SHD in 1998 he worked for a Construction company in Wyoming.

Kyle Devine, Health Program Specialist II, received his MSW from University of Nevada Reno, and is the Bureau's Child and Adolescent Coordinator. Prior to coming to the State he worked for Lassen Diversified Management of Susanville California in charge of their Tobacco Control initiative. This unit includes three Health Program Specialist Is, for Early Childhood Systems Development birth to five, Childhood Systems Development ages six to ten, and Abstinence-Only. It has an Administrative Assistant I assigned to it. ***/2007/ This position will be taking over rape and injury prevention, the MCH Campaign, and Perinatal Substance Abuse Prevention when the Bureau is reorganized. This would include the 2 HPS Is. //2007//***

Christine Forsch, Health Program Specialist II, Oral Health Program Manager, is a graduate of Kennedy Western University, and a Registered Dental Hygienist (RDH). Prior to becoming the Oral Health Program Manager, she served as the State's Oral Health lead as a contractor in the Bureau. ***/2007/ Ms. Forsch has changed her name back to her maiden name and is now Chris Wood. She was recently elected president-elect of the Association of State and Territorial Dental Directors. //2007//***. In addition the Oral Health Program has a Biostatistician, a half-time Health Educator, two half-time RDH contractor educators, a contracted half-time collaboration specialist and a contracted half-time time evaluator. There is an Administrative Assistant II assigned to it. ***/2007/ One of the half-time RDH contractors is now a .75 FTE. //2007//***

Debra Wagler, Health Program Manager I, Real Choice Systems Change, received her MA from California State University. She also has a MA from Nanyang Technological in the Republic of Singapore. The RCSC initiative also has a Management Analyst II, and an Administrative Assistant I assigned to it. ***/2007/ This program has been moved to the block grant for continued systems development. The MA II is being moved to form the beginning of a MCH EPI unit for the Bureau. Ms. Wagler will continue working on CSHCN systems development. //2007//***

Doug Schrauth, Health Program Manager II, WIC Manager, is a graduate of Cal-State University in Hayward, CA. Before coming to be WIC Manager in 2002 he was SHD Internal Auditor. The State WIC Office has a Health Program Specialist II Registered Dietitian, a Management Analyst II, a Computer Services Technician II, an Accounting Assistant and an Accounting Technician. There is an Administrative Assistant III assigned to it for vendor monitoring and training. WIC now has an office in Las Vegas, which has a Health Program Specialist I breastfeeding Coordinator, and will have a Health Program Specialist I trainer. The Las Vegas office has a contracted Administrative Assistant. It will house the Birth Defects Registry HPS I when that vacancy is filled. ***/2007/ Doug has now moved to a Health Resource Analyst 1 position in the PCDC. The new WIC Program Manager is David Crockett. David has a BS from The Citadel (Charleston, SC, and a MS from the University of Utah in Management. He has also had training from the U.S. Air Force while he was in the military. He comes to WIC from the Bureau of Community Health Services AIDs Program, where he was a HPS II. His CV is in the attachment to this chapter. The HPS 1 Trainer for Las Vegas position has been filled. //2007//***

In 2003 the WIC program released a Request for Application for WIC agencies who would take over state run clinics in the rural counties (the urban counties Washoe and Clark were already served by contracted agencies). This RFA was completed and a second one released that has

been left open. The goal is to have the state WIC office get out of providing direct services and assume a solely management role. At this time only four rural counties have state-run WIC clinics, Douglas, Humboldt, Churchill and Pershing. The remainder have been turned over to locally community-based organizations that include Family Resource Centers and Head Start. There are also additional contractors in Clark and Washoe Counties. Additionally, WIC is on task to convert WIC benefits to Electronic Benefit Transfer (EBT). It has added contracted staff to work on the conversion. It has also added a contractor to help with vendor monitoring and a contractor to help with financial management of the program, for a total of 4 WIC contractors. WIC is currently undergoing a reengineering study to help it determine its configuration after conversion from state to locally run clinics and the impact of EBT on the caseload. This study is due this summer. WIC currently has 26.79 FTEs, but this will change in the coming year. ***/2007/ The contractor for financial management is now an FTE Accountant 2; the Vendor monitor, based in Las Vegas, is also now an FTE. There are now only 3 state-run WIC clinics,Douglas, Humboldt and Churchill. WIC has also added 3 Health Program Specialist 1s, 1 in Carson City and 2 in Las Vegas. It is currently studying its configuration to address the conversion from manual checks to Electronic Benefit Transfer cards for WIC benefits. In the coming year more computer support staff will probably be added. With the conversion of all but 3 WIC clinics to private providers WIC now has 19.77 FTEs, 10 of them in the state office and 5 in Las Vegas. In this past year WIC opened a state office in Las Vegas. When hired the breast feeding coordinator will be based there.//2007//***

/2007/
The Birth Defects Registry Health Program Specialist 1 position has been filled by Prasanjit Chakma. Mr. Chakma graduated from Chittagong Medical College, Bangladesh, with a MBBS in Medicine. He then completed an MPH at the University of Wales College of Medicine, Cardiff, Wales. He is currently working on a MS at California State University. He is based in Las Vegas. He is housed with the Cancer Registry in Las Vegas.

Outside of WIC the Bureau has an additional 40.26 FTEs. The Bureau also has several temporary employees filling positions in Oral Health, CSHCN, and WIC. Several of these will be converted to FTEs in the future, perhaps the coming year. //2007//

An attachment is included in this section.

E. State Agency Coordination

As indicated in III.C, the agencies of public health (State Health Division), mental health (Division of Mental Health/Developmental Services), social services/child welfare (Division of Child and Family Services), Medicaid and Nevada Check Up (Division of Health Care Financing and Policy), Aging and TANF and Child Care (Welfare) are located within the Department of Human Resources. The Bureau works closely with all the Divisions of DHR to promote MCH priorities and objectives, described below.

The Bureau works closely with all the Bureaus of the SHD in one manner or another as discussed in III.B and IV.B and IV.C. This includes the Bureaus of Alcohol and Drug Abuse (BADA), Health Planning and Vital Statistics (HP&VS), Health Protection Services (HPS), Community Health (BCH), Licensure and Certification (BLC), and the newest Bureau, the Bureau of Early Intervention Services (BEIS) which joined the SHD in FY04. The main office of BEIS is collocated with the Bureau in Carson City.

The Bureau partners with the Department of Education and with local (county) school districts

around the state on many initiatives around child and adolescent health. These include the Youth Risk Behavior Survey (which includes the Safe and Drug Free School Survey), Teen Pregnancy Prevention, and Perinatal Substance Abuse including Fetal Alcohol Syndrome Prevention. It works with the Department of Education on an oral health curriculum for schools. The Bureau also works with Juvenile Probation of the Department of Corrections on teen pregnancy prevention, substance abuse, and injury prevention.

The Bureau is partnering through the MCH Campaign with the Department of Corrections to promote healthy birth outcomes in incarcerated women and good parenting. The Perinatal/Woman's Health Consultant is developing training modules that will be used by Department of Corrections staff, including one on the stages of pregnancy and another on an infant's health. Modules have also been completed on Postpartum issues and Infant Development.

The 2001 Nevada Legislature passed AB513, which appropriated funds for the development of four long-term strategic plans relating to the health care needs of Nevada residents. The project was lead by a Steering Committee to which four Task Forces report, one of which is for Disabilities. The other Task Forces were for Seniors, Rural Health and Rates.

The Disability plan was charged to "ensure the availability and accessibility of a continuum of services that appropriately meet the basic needs of persons with disabilities in Nevada". Based on this study the 2003 Legislature moved Community Based Services from the Department of Employment, Rehabilitation and Training (DETR) to DHR and also created in DHR a new Office of Disability Services and moved DETR's Traumatic Brain Injury program into it. The Bureau is working very closely with the new Office of Disability Services and Community Based Services. In particular the Office of Disability Services is working closely with the Real Choice Systems Change (RCSC)project discussed in III B.

The RCSC project team has developed an interagency working group to bring all providers of services for the CSHCN population together. This CSHCN Advisory Council's membership includes parents of CSHCN, adolescent CSHCN, advocates, providers, and educators. The Advisory Council serves to guide project activities and to provide a forum for issues of interest to Nevada's CSHCN and their families. The Real Choice program manager acts as a liaison between the Advisory Council and the Children's Disability Subcommittee created as part of the Disability Task Force to assure that project activities are in line with the objectives of Nevada's Strategic Plan for People with Disabilities. While coordination with some agencies is easier than with others, there has been interest in developing a cross-departmental system of care for CSHCN and the RCSC project is working to take advantage of this culture of change.

The Real Choice Project Team has also been attending meetings of and working with the Transition Forum, a subcommittee of the Governor's Council on Rehabilitation and Employment of People With Disabilities. This forum addresses issues inherent to transitioning youth with special health care needs and has formal relationships with DETR and school districts.

The Bureau works closely with the University of Nevada School of Medicine (UNSOM). The Birth Defects Registry initiative currently in process will partner with the UNSOM Department of Pediatrics' Geneticists to provide consultation in its development and implementation. Bureau staff contract with some and otherwise support UNSOM participation in multi-disciplinary clinics for CSHCN that include Genetics, and Cleft/Craniofacial clinics in Reno and Las Vegas. In 2005 the Bureau is working with the geneticist of UNSOM to establish a Fetal Alcohol Syndrome (FAS) multidisciplinary clinic in Las Vegas. Once this clinic is established a plan will be created to have a FAS clinic in the north. The Bureau also works closely with AHEC, whether it is using their expertise to plan and conduct meetings or the partnership with PCDC on rural mental health issues.

The Bureau partners closely with the Clark County Health District (CCHD) and Washoe County

District Health Department (WCDHD), which both have MCH programs. A third Health District, Carson City (which is a County), was added late in 2004. There are now three county health departments in Nevada. The remaining 14 counties are served through the SHD. Representatives of the CCHD and WCDHD sit on the Maternal and Child Health Advisory Board and work very closely with the Bureau on MCH issues. ***/2007/ The CCHD has been renamed to the Southern Nevada Health District (SNHD).//2007//***

Through the PCDC the Bureau works very closely with the Great Basin Primary Care Association (GBPCA, the state's PCA) and its members to promote access to primary, dental and mental care for underserved Nevadans. These members include Federally Qualified Health Centers, Tribal Clinics, Rural Health Centers, Nevada Health Centers, etc. The executive director of GBPCA is the current chairman of the Maternal and Child Health Advisory Board. Nevada Health Centers has just become a WIC provider in southern Nevada.

The WIC Program is in the Bureau and partners with many of the other programs in the Bureau such as Oral Health and Women's Health/Perinatal. In the past year WIC has been turning its state-run clinics over to local community-based organizations who are now partners with WIC. It has also gained additional WIC agencies in Clark and Washoe Counties. As this is written there are state-run clinics in just Douglas,Churchill, Humboldt, and Pershing counties; the rest are run by CBOs that include Family Resource Centers, a Head Start, Nevada Health Centers, and a hospital. A proposal by Pershing County to take over WIC was received in June 2005.

The Teen Pregnancy Prevention initiative works with the various Family Planning organizations in the State, including those services of the Community Health Nurses of BCH and the private organizations in Reno and Las Vegas. In 2004 Nevada was one of several states selected to work together on developing a common Action Plan around Teen Pregnancy, STD, and HIV/AIDS prevention. This initiative is continuing and will continue into FY 06. The Stakeholders Group, as it is called, is now looking at approaching the issues of teen pregnancy, HIV and STD prevention from an adolescent risk reduction perspective. This will be discussed more under National Performance Measure 08.

The Oral Health initiative also has many partnerships. The State Dental Health Consultant (to the CDC grant) is from the University of Nevada Dental School. The initiative has both a state advisory committee and local coalitions in Reno, Washoe, and Lyon counties, with more in process. Members of the various coalitions and the state advisory committee include representatives of the State Dental Association, State Dental Hygienists Association, the State Board of Dental Examiners, UNSOM, the Dental School, consumers, the GBPCA, Washoe County District Health Department, Clark County Health District, Tribal Health, local Churches, a hospital and the State Aging Division. Meetings are usually attended by representatives of other public agencies that include Medicaid and the Nevada Public Health Foundation.

Through the partnership the Bureau has with Medicaid and Nevada Check Up, Bureau programs are referral sources for both programs. Bureau staff are able to access the Medicaid data system to confirm Medicaid eligibility or ineligibility when considering eligibility for the CSHCN Program. The Bureau has a contract with Nevada's Division of Health Care Financing and Policy (Medicaid) to provide public education through the Maternal and Child Health Campaign about the importance of early and continuous prenatal care, other pregnancy related issues and infant care. Pregnant women and infants and children are also informed about the Medicaid (including EPSDT) and Nevada Check Up programs and referred to the programs if indicated. In addition, the Real Choice Systems Change project has worked with Medicaid and Nevada Check up staff on an outreach campaign to sign children up for Medicaid and Nevada Check Up, and perform outreach for CSHCN services at the same time. The Bureau's pilot projects for RCSC will work with DHCFP to increase EPSDT usage by Medicaid children, a goal of the grant.

The CSHCN program also uses SSI for a referral. Program regulations require a denial from Medicaid, SSI, and Nevada Check Up for those children whose family income and for SSI the

child's condition appear to meet those eligibility criteria.

Through the various programs in the Bureau the Bureau has contact with all the birthing facilities in the State. It works with them on issues such as newborn screening, newborn hearing screening, the Birth Defects Registry, and the MCH Campaign. In 2004 it worked with representatives of all the NICUs in the state to revise the NICU regulations that are in NAC.

Along with moving all Early Intervention Services to the SHD, the Director also moved the Head Start State Collaboration to the Welfare Division with the Child Care Unit. The 2005 session is now moving it to the DHR Director's office. The Bureau has representation on both the Head Start State Collaboration (the Bureau Chief and Oral Health) and the DHR Child Care Advisory Committee (the Bureau Chief) and ensures that health needs including those of CSHCN are part of every discussion of services. Both the Head Start State Collaboration and DHR Child Care Advisory Committee have similar memberships and frequently have similar agendas items. In June of 2005 it became clear that the Head Start mandate to a strategic plan and the Early Childhood Comprehensive Systems (ECCS) strategic plan are addressing the same populations. The two initiatives are being combined to produce one plan for ECCS that includes Head Start.

As noted in III.B, the Child Care Health Consultant (CCHC) program is in transition due to lack of funding and loss of their lead Child Care Health Consultant trainer. The MCH funded member continues to be available to child care providers for consultation and to train staff in the prevention of illnesses within a child care setting. The Bureau's Early Childhood Comprehensive Systems program is working to continue this program. The CCHC leadership is being transferred from the University of Nevada, Reno, to the Bureau where it is being integrated into the ECCS program. The Bureau is awaiting word on where the training for CCHC trainers (train the trainers) will be in the future. Plans are to send two or three community health nurses from BCH for training as trainers. They will then train all the CHCs as CCHC. This will take care of rural communities. The Welfare Division, Child Care Unit, has agreed to cover the salaries of two nurses who are already trained in Washoe County. This will leave Clark County with a need for CCHC trainers, which will not be addressed until next year.

/2007/ As previously noted DHR is now the Department of Health and Human Services (DHHS).

A Fetal Alcohol Syndrome multidisciplinary clinic has been established in Las Vegas. Plans continue to develop one in the north.

The Chairman of the MCHAB is now an obstetrician who is a prior chairman of the Nevada chapter of ACOG.

Pershing County is no longer a state run WIC clinic, leaving just Douglas, Churchill and Humboldt counties for the state.

The ECCS State Plan is in the process of being completed and will be finished by the end of July 2006.

The Oral Health Program convened a one-day coalition building workshop for members of Nevada's oral health coalitions in Las Vegas on June 5, 2006. There are now 6 oral health coalitions in the state, one in Reno, one in Las Vegas, one for rural Carson City and Douglas Counties, a northeast coalition, a central Nevada coalition, and a newly forming one in Churchill, Lyon, Pershing and Storey Counties. Other activities continue as listed.

Unfortunately the plan to address the Child Care Consultants has had to be put on hold due to staff changes.

Collaborations and Coordinations for the Teen Pregnancy Prevention initiative are

discussed in the Annual Plan for NPM 8 and SPM 4.

The RCSC project continued the projects detailed above. It has continued collaboration with other activities going on in the State around disability services, including the Governor's 10 year Strategic Plan for People with Disabilities. It supported a conference on the Olmstead Decision in Reno and again in Las Vegas in March 2006 which brought together most of the state players in the disability field. It is currently working with other CMS grantees and other interested agencies in the state to submit a proposal to CMS for a Systems Transformational grant. Development of the 2-1-1 system is ongoing.

For the rest there is no change.

//2007//

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	42.1	47.7	44.2	44.9	46.4
Numerator	655	761	730	752	833
Denominator	155714	159405	165242	167306	179563
Is the Data Provisional or Final?				Final	Final

Narrative:
The Center for Health Data and Research (CHDR) has the primary responsibility for obtaining the data for this application, including that for the Health Systems Capacity Measures (HSCM) and Indicators (HSCI). They worked with Bureau staff to obtain the data for this report that is not contained in the CHDR's data warehouse. The warehouse includes birth and death certificates, hospital discharge data, WIC, Medicaid encounters, census and demographic data, Trauma Registry, etc. and is able to produce most of the HSCI data through data linkages. There are currently over 30 databases in the CHDR data warehouse.

HCSM # 1 has seen an increase in the rate of children hospitalized for asthma, from 44.9 in FY04 to 46.4 per 10,000 children less than five years of age in FY 05. While this is not a significant increase, there hasn't been much change in the state's response since last year. The BCH is the lead on this initiative, with the Bureau working with them. As a desert state with a lot of pollen, a drought of some longevity, and a lot of dust stirred up during the ongoing building in Clark County, the increase in the asthma rate is not unexpected. This data is from the CHDR data warehouse.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	51.2	53.8	44.9	50.8	73.9
Numerator	8721	10354	8919	11337	10917
Denominator	17027	19241	19876	22299	14775

Is the Data Provisional or Final?				Provisional	Final

Notes - 2005
Data for this indicator is from Medicaid.

Narrative:
HCSM # 2 has seen a major increase. Medicaid managed care continued to increase its numbers in southern Nevada and added Northern Nevada when a second HMO became available there, which also contributed to this increase. The MCH Campaign has an Information and Referral Line (IRL), a multi-media information campaign, and a network of pediatric (and prenatal) providers who will accept Medicaid (and Nevada Check Up) that the IRL can refer callers to. The MCH Campaign is a partnership between SHD and Medicaid. The Real Choice Systems Change project partnered with Medicaid and Family Voices in a media campaign encouraging parents to register their children in Medicaid and take them in for services. Medicaid reported this data.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	14.5	65.4	39.5	37.2	91.7
Numerator	192	540	5541	3064	881
Denominator	1328	826	14035	8238	961
Is the Data Provisional or Final?				Provisional	Final

Notes - 2005
This measure is from the Nevada Check Up web page for July 1, 2005, the number on the program. The number served is reported from the program.

Notes - 2004
This data is from Nevada's S-CHIP office. It cannot be validated.

Notes - 2003
This data comes from the Division of Health Care Financing and Policy. Their data systems over the years have not been as reliable as they could have been. The Health Division reports what DHCFP provides.

Narrative:
HCSM # 3 has seen a significant increase. This data is taken directly from reports on the Nevada Check Up website. The rates can also be linked to managed care as children in both Reno and Clark County have to belong to the Medicaid managed care agencies in those communities. The Nevada State Legislature has continued to approve increased state funding to match the SCHIP dollars. Nevada Check Up has recently seen a decrease in applications and is currently analyzing why.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005

Annual Indicator	70.6	78.5	80.5	75.9	69.6
Numerator	22001	24156	26957	26581	25391
Denominator	31163	30767	33468	35022	36485
Is the Data Provisional or Final?				Final	Final

Narrative:
HCSM # 4 has seen a little decrease, going from 75.9 % in FY 04 to 69.5 % in FY05. As noted in IIII.B., Agency Capacity, the MCH Campaign's message on early and continuous prenatal care will continue into FY 07. The contracts with community-based organizations for care for underserved pregnant women in Las Vegas and Reno will continue in FY 07. Women served by these organizations can have no other resource for prenatal care. The Bureau will also be looking into the thought, particularly in the south, that physicians are not seeing women for prenatal care until their 12th week. It will look to quantify this premise. This data is from the CHDR data warehouse.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	90	90	90	97.5	30.8
Numerator				95000	43250
Denominator				97436	140403
Is the Data Provisional or Final?				Provisional	Final

Notes - 2005
Data for this measure was provided by Medicaid.

Notes - 2003
Medicaid was unable to provide data regarding the number of potentially eligible who received a service paid by Medicaid.

They were able to indicate that 146,198 individuals under 20 years were eligible for an EPSDT exam, and that there were 109, 679 EPSDT screens completed. (There may be some duplication in this number due to the periodicity schedule).

Narrative:
HSCM 07A. These numbers clearly point to the need to do Medicaid outreach. It is the first time that the Bureau has had a numerator and denominator for this measure. As noted in HSCM # 2 the Bureau partnered with Medicaid in an outreach campaign in FY06 and has placed links to the Medicaid application on its CSHCN web page. The Bureau and its partners are watching very closely the recent change in Medicaid policy to require documentation of citizenship for its impact on applications. This data came from Medicaid.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	28.4	22.7	15.7	15.6	26.3
Numerator	5930	5618	6517	5357	7569
Denominator	20859	24784	41429	34278	28746
Is the Data Provisional or Final?				Provisional	Final

Notes - 2005
Data for this measure was provided by Medicaid.

Notes - 2003
Data is not available for 1999, so zeros were used in order to save this measure.

Narrative:
HCSM # 07B. There has been an increase in dental providers who will see children on Medicaid, with a new practice opening up in Reno who primarily serves this population. This significantly increased access to dental care for Medicaid eligible children in the north. Changes were also made to the Medicaid managed care program in the south that also made it easier for a child to get into a dentist for care. This data came from Medicaid.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	23.1	20.6	20.5	20.5	20.8
Numerator	863	638	953	1054	1054
Denominator	3730	3100	4653	5140	5077
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:
HSCM # 8. The percent of SSI beneficiaries receiving services from CSHCN fluctuates from year to year depending on how many children are served by Early Intervention and other factors. The only children served by both SSI and CSHCN are those seen in Early Intervention and in the specialty clinics. This number comes from the estimated number of children served by Early Intervention who are on SSI (numerator) and the number of children total on SSI for CY 05 (denominator).

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2005	matching data files	7.1	7	7

Notes - 2007
Medicaid and Non-Medicaid numbers are estimated based on the percentage of the state overall numbers and ratio of last year since Medicaid data is available in a limited format.

Narrative:
Form 18. HSCI # 5. The Bureau partners with Medicaid, and soon Nevada Check Up, to get underserved women into prenatal care. Those on Medicaid appear have a little better record of getting into care early. The infant mortality shows little variation. The HEDIS measures for

"Weeks of Pregnancy at Time of Enrollment in the (Medicaid) MCO" indicate only 2% got into care in the first 12 weeks. Sixty-nine percent entered care at 28 weeks or more for one HMO; for the other HMO 52 % were enrolled at the time of pregnancy, with 30% entering care at 28 weeks or more. This data comes from the CHDR data warehouse.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2005	other	5.6	5	5.3

Notes - 2007
Medicaid and Non-Medicaid numbers are estimated based on the percentage of the state overall numbers and ratio since Medicaid data is unavailable. Update. Medicaid was able to provide the number of infant deaths (164) but this number included those lost to miscarriage after 26th week of gestation.

Narrative:
See the note for 5A. This data is from the CHDR.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2005	other	71	65	67.3

Notes - 2007
Medicaid and Non-Medicaid data is estimated due to the percentage of state overall numbers and ration since Medicaid data is unavailable.

Narrative:
See the note for 5 A. This data is from the CHDR.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2005	other	72	67	69.6

Notes - 2007
Medicaid and Non-Medicaid data are estimates based on the percentage of state overall numbers and data since Medicaid data is unavailable.

Narrative:
See the note for 5A. This data is from the CHDR.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2005	133
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2005	200

Narrative:
Form 18. HSCI # 6. This indicator is self explanatory. The information is contained in Medicaid and Nevada Check Up manuals and on their websites. As previously noted, Nevada Check Up has a waiver request in to raise eligibility for pregnant women over age 18 to 185% FPL. The hope now is that it will be approved by September 1, 2006. Once approved this information will be shared with WIC agencies as they are a logical referral source for pregnant women with this change (their FPL is also 185%). WIC agencies have been advised that this change is coming and are waiting for it.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2005	 133 100

INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2005	200

Narrative:
See the note for 6A. This data hasn't changed for years.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2005	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2005	200

Notes - 2007
Pregnant women are served by SCHIP only to age 18 in 2005. DHCFP has requested a waiver to serve pregnant women over age 18 who are not eligible for Medicaid to 185% of poverty starting September 1, 2006.

Narrative:
See the note for 6A. If the indicator level for Nevada Check Up changes, it won't be until September.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC	3	No

eligibility files		
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	1	No

Notes - 2007

Nevada contracts with the Oregon Public Health Laboratory (OPHL) to do newborn screenng testing. OPHL maintains a database of all specimens and results, as well as demographic data. This data is now avaialable to Nevada's biostatistician for data matching and reports.

In addition, Nevada's data file is available on-line from OPHL to the Nevada Newborn Screening Coordinator for individual (one by one) case file inquiries regarding case status, results, and demographic information.

Nevada has a birth defects registry that is accessible to MCH staff and is also on a network that is part of a data warehouse. This data warehouse is accessible to the state biostatistician for use in a variety of reports and data matches.

Narrative:

Form 19. HSCI # 9A. This data comes from the CHDR. For the first time this year birth certificates and newborn screening records were matched (Form 6). The Bureau access is through working with the CHDR. It has placed an FTE funded by its SSDI grant to work on the data warehouse as it relates to MCH. That FTE has direct access to the data bases. State statute does not allow surveys such as PRAMS which go back to birth certificates for those to be surveyed. The CHDR and Bureau are considering other ways to get PRAMS type data.

SSDI supports the linking of the following databases:

a. Infant birth
b. Infant death
c. WIC eligibility
d. Newborn screening
e. Birth defects registry
f. Medicaid and Nevada Check Up (S-CHIP) eligibility claims
g. Hospital discharge
h. YRBS

The CHDR is headed by Wei Yang, MD, Ph.D., Biostatistician.

Nevada's Birth Defects Registry (BDR) is now an "active" registry, collecting information primarily from hospital records. BDR staff will have all of CY 2005 data collection completed by the end of July 2006, giving the State one full year of data. The FTE for this project is funded by newborn screening fees as directed by the 2003 legislature. He is based in Las Vegas where the majority

of state births occur.

The CHDR does not have electronic access to the Pediatric Nutrition Surveillance System (which is collected on WIC clients). This data is sent to CDC for analysis.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2007

Narrative:
Form 19. HSCI - 9B YRBS. The State Department of Education conducts the Youth Risk Behavior Survey along with the Safe and Drug Free School Survey. It is given to middle and high school students, with some of the questions not appropriate for middle-schoolers left off the questionnaires distributed to them. Nevada is one of the few states that has weighted data so that each school district can have data that is weighted for its local use. The State Department of Education has given the YRBS database to the CHDR. The Child and Adolescent Program is currently asking Nevada's counties for county specific data to help with targeting prevention activities. To date 10 have provided this data. The 2005 YRBS reported that 18.3 % of adolescents in Grades 9 through 12 reported using tobacco in the past month.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Nevada's priorities and initiatives are based on the MCH/CSHCN Five-Year Needs Assessments completed in January and May 2005. "Focus groups" were established to publicly discuss the inadequacies and inequalities among the 3 MCH populations in Nevada (pregnant women and infants, children and adolescents, and CSHCN). The focus groups were a tool to build bridges among traditional and non-traditional partners in the community; they were a primary source of information that helped shape the foundation of the Year 2000 Needs Assessment. In an improvement over the 2000 Needs Assessment, the Bureau was able to utilize the data warehouse in the CHDR for Primary and Secondary data sources. No additional surveys needed to be done. Presentations were also made to the Maternal and Child Health Advisory Board and the Governor's Youth Advisory Council, and a statewide video-conferenced public hearing was held to discuss preliminary findings and shape the final outcomes of the Needs Assessment. The persons involved in the Year 2005 Needs Assessment were very vocal, creative, and mindful of the populations they serve.

The priorities identified by the Year 2005 MCH Needs Assessment include:

An overarching approach to Nevada's priority needs identified below, continues to be to identify ethnic, gender and age demographics of targeted populations, and use culturally appropriate assumptions and strategies to design and implement initiatives.

1. Increase access to primary care services, providers, facilities, resources, and payor sources among the MCH populations.

2. Increase access to oral health services, providers, facilities, resources, and payor sources among the MCH populations.

3. Increase access to mental health services, providers, facilities, resources, and payor sources among the MCH populations.

4. Create a unified data system and surveillance system to monitor services delivered to the MCH populations.

5. Create "braided" services for CSHCN resources in Nevada including "one-stop-shopping" and "no-wrong-door" models of service delivery.

6. Increase financial coverage and decrease financial gaps for health services among the MCH populations

7. Decrease the incidence of domestic violence among women of child-bearing age

8. Decrease the risk factors associated with obesity for children and women

9. Decrease unintentional injuries among the MCH populations

Eight State Performance Measures were developed from the nine priorities to complement the 18 National Performance Measures. The eight are:

1. The percentage of women of childbearing age who receive screening and assistance for domestic violence should be increased.

2. Access to preventive oral health services for the Medicaid population of children and youth

should be increased.

3. Obesity among women ages 18 to 44 will be decreased.

4. Teen pregnancy birth rates among Hispanic adolescents ages 15-17 should be reduced.

5. All infants born in the state will have a newborn hearing screening prior to discharge from the hospital.

6. The percent of children and youth ages birth through aged 18 who die from unintentional injuries should be decreased.

7. Increase the ratio of primary care providers to the number of children and youth ages birth to twenty-one and women of child bearing age.

8. The percent of children ages birth to twenty-one including CSHCN and women of child bearing age who have access to mental health services, regardless of the ability to pay, should be increased.

/2007/ There has been no change to Nevada's Priorities or State Performance Measures. The State Performance Measures were established as sentinel measures for the priorities, with the proviso that there be data available for them. //2007//

Outcome Measures (OM)1 through 5 lead to the issue of achieving a healthy pregnancy and birth outcome. For FY06, the primary efforts of the MCH Program on achieving healthy birth outcomes will be achieved through the Bureau's MCH Campaign and Child and Adolescent Health Programs discussed in III B. The Teen Pregnancy Prevention campaign will continue to work to prevent teen pregnancies, which can lead to low birthweight babies.

For OM 6 the partnerships of Injury Prevention will continue work together to address preventing the deaths of children aged 1-14. The Bureau's Injury Data Surveillance Project produced "An Analysis of the Injury Surveillance Data System in Nevada" in FY 04, which guides the Injury Prevention initiative. The domestic violence and child abuse and neglect activities such as P.A.N.D.A. will continue.

The 2003 Legislative session established a Child Death Review process that involves 2 teams, staffed by DCFS. One team is Executive, on which the Bureau's Women's Health Coordinator sits representing Public Health. It is charged with reviewing child death reports from local teams and making recommendations for state policy changes and outreach campaigns to change behavior. It is comprised of representatives of child death review teams from around the state, public health, vital records, medical personnel, law enforcement, the office of the Attorney General, and a coroner. The other team is Administrative, on which the MCH Chief sits representing Public Health. It is comprised of Administrators from Child Welfare agencies, State agencies of Vital Statistics, Public Health, Mental Health, Public Safety, Child and Family Services, and Clark and Washoe County Departments of Social Services. The purpose of the Executive team as stated in NRS 323B.403-409 is to review the records of selected cases of deaths of children under 18 years of age in the state; review the records of selected cases of deaths of children under 18 years of age who are residents of Nevada and die in another state; assess and analyze such cases; make recommendations for improvements to laws, policies and practice; support the safety of children; and prevent future deaths of children. The Administrative team shall review the (Executive team's) report and recommendations and respond in writing to the multidisciplinary team within 90 days after receiving the report. An annual report including statistics and recommendations for regulatory and policy changes is to be produced.

B. State Priorities

Nine priorities were identified by the Nevada Year 2005 MCH Needs Assessment.
They include:

1. Increase access to primary care services, providers, facilities, resources, and payor sources among the MCH populations.

2. Increase access to oral health services, providers, facilities, resources, and payor sources among the MCH populations.

3. Increase access to mental health services, providers, facilities, resources, and payor sources among the MCH populations.

4. Create a unified data system and surveillance system to monitor services delivered to the MCH populations.

5. Create "braided" services for CSHCN resources in Nevada including "one-stop-shopping" and "no-wrong-door" models of service delivery.

6. Increase financial coverage and decrease financial gaps for health services among the MCH populations.

7. Decrease the incidence of domestic violence among women of child-bearing age.

8. Decrease the risk factors associated with obesity for children and women.

9. Decrease unintentional injuries among the MCH populations.

See the attached Needs Assessment for a discussion of these priorities.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			99	99	99
Annual Indicator		98.3	99.6	99.0	98.4
Numerator		32253	33036	34384	35794
Denominator		32798	33168	34730	36377
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	99	99	99	99	99

Notes - 2005
For the first time this number is from a match of newborn screen records and birth certificates.

Notes - 2004
Information is based on data from the Nevada Newborn Screening program contract laboratory - the Oregon Public Health Laboratory, which maintains a computer database of all screening tests submitted and the results. Nevada has always had an excellent participation rate of newborns receiving at least one initial screening prior to discharge. Despite the rapid population growth in the state - hospitals and thier staff remain committed to continuing to assure all infants have a

specimen taken and tested. Thus, it is anticipated that the percent of newborns receiving an initial screen will remain the same.

a. Last Year's Accomplishments

NPM # 1: FY 05. The data source for this measure is state CSHCN Newborn Screening database and birth certificates. This measure is both direct services and population based. The number is from a match of birth records to newborn screening records. FY 05. 98.4%

Nevada has contracted with the Oregon Public Health Laboratory (OPHL - a regional laboratory) to do its newborn screening since the early 1970's. OPHL and contracting state agencies developed a tracking and follow-up system that is one of the leaders in the newborn screening community. Protocols and educational materials for the newly adopted Tandem Mass Spectroscopy testing were developed. Brochures and practitioner manuals were adapted and are distributed statewide. OPHL also provides specialist consultation to the laboratory through a contract with the Oregon Health Sciences University, and to primary care providers (PCPs) in Nevada for confirmatory testing and the initiation of treatment. The SHD contracted with a metabolic geneticist to provide ongoing clinical consultation in Nevada to individuals who have been diagnosed with a metabolic disorder and their providers. Infants with an endocrine or hematologic disorder are seen by specialists in the private sector. The CSHCN Program assists with coverage of the definitive diagnosis, lab testing and initiation of treatment. The metabolic specialist saw infants, children and a limited number of adults. Registered dieticians from the Early Intervention clinics (EI), who have received special training in the treatment of these rare metabolic disorders, provided nutrition consultation. The specialist and dieticians offer not only medical management of the disorder, but also counseling relative to the importance of initiation of the special diet prior to becoming pregnant. In the last few years, females with metabolic disorders who wish to become pregnant have returned to the clinic for specialist and dietician services prior to and throughout their pregnancy in order to achieve a healthy birth outcome. Finally, the CSHCN Program worked to ensure all CSHCN with metabolic disorders received the services they need.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Nevada NBS program screened 98.4% of infants born in the State.			X	
2. The Nevada NBS program supports specialty metabolic clinics for children determined to have a metabolic disorder.		X		X
3. The Nevada NBS and CSHCN programs provide coverage for the diagnosis and treatment of metabolic, endocrine and hemoglobin disorders.	X	X		
4. The Nevada NBS and CSHCN programs work with Early Intervention services to provide specialty nutrition services to families of children born with metabolic and other developmental disorders.	X	X		
5. The Nevada NBS program and CSHCN programs maintain a "registry" of NBS cases.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

NPM # 1: FY 06. Nevada continues to have one of the top programs for Newborn Screening in the nation. 98.4%-of Nevada's newborns are screened for Amino Acid Disorders, Organic Acid Disorders, Fatty Acid Disorders, Hypothyroidism, Congenital Adrenal Hyperplasia and Hemoglobinopathies. In addition, 86-88% of newborns receive a second confirmatory screening. The Nevada Newborn Screening program continued to contract with the Oregon Public Health Laboratory (OPHL) to provide expanded testing of infants using Tandem Mass Spectrometry. The implementation of "expanded" testing has increased the number and intensity of follow-up activities for staff, and has also provided an additional element of quality to Nevada's already successful program. Data is obtained through State vital statistics (birth certificates) and Newborn Screening records. (Note: this measure reports screening for all newborns born in the State, regardless of state of residency. There is no data at this time available on newborn screening for those resident infants born out of State.)

The SHD continues to contract with a Metabolic Geneticist to come to the state on a regular basis to see children with inborn errors of metabolism - and women of child-bearing age with a metabolic disorder - who are considering getting pregnant. Individuals are seen by the clinical Metabolic Geneticist at the E.I. clinics, where they receive not only Geneticist consults, but ongoing access to registered dieticians who have special training in managing these disorders. The Metabolic Geneticist will also consult by phone with any physician in the state with a metabolic question; this consultation is a provision of the contract.

Those individuals who are detected by the program as having a possible metabolic, endocrine or hemoglobin disorder are referred to the Metabolic Geneticist, Endocrinologist, or Hematologist for confirmatory testing and ongoing treatment if necessary. The child is automatically referred to the CSHCN and Early Intervention programs for continued follow-up services. The CSHCN program provides appropriate referral to a variety of resources and maintains a "registry" of infants found to have a disorder detected by the NBS program. The registry triggers an annual update with the family to determine if the family's status has changed and to assure that the child is still receiving necessary services.

Note: Nevada's newborn hearing screening also meets national goals. (See NPM 12)

c. Plan for the Coming Year

NPM # 1: FY07. The SHD will continue to contract with the Oregon Public Health Laboratory (OPHL) to provide "expanded" Tandem Mass Spectrometry testing. This program will provide "state of the art" testing for thirty-one disorders to Nevada's successful program. The OPHL Laboratory contract will continue to contract with metabolic, endocrine and hemoglobin specialists to provide consultation and initiation of testing and treatment. Two specimens will continue to be taken to assure no "missed" cases. When additional information regarding the specificity of the new methodology becomes available, Nevada will evaluate the necessity of two specimens at that time.

OPHL is in the process of gearing up to add testing for Cystic Fibrosis to its current availalbe test panel. Nevada will need to evaluate adding this to its state panel. The availability of appropriate medical services, follow up capacity and need for increased fees will be part of that consideration.

The SHD will continue to contract with a Metabolic Geneticist to provide ongoing clinical consultation to children born with metabolic disorders and women of childbearing age with PKU and other metabolic conditions that want to have children. The Metabolic Geneticist will also consult by phone with any physician in the state with a metabolic question; this consultation is a provision of the contract.

All infants detected with an inborn error of metabolism, endocrine or hemoglobin disorder will continue to be automatically referred to the Children with Special Health Care Needs (CSHCN)

program for coverage of needed physician, laboratory and nutrition services. CSHCN refers these babies to the E.I clinics for a full developmental assessment. MCH funded nutritionists based in the Early Intervention clinic will continue to provide ongoing nutrition guidance to metabolic cases and the program

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			55	58	60
Annual Indicator		54.6	54.6	54.6	54.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	65	70	80	85	85

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
NPM # 2: FY 05. (SLAITS data, which will not change until the study is updated) 54.6, see also State priority 5.

Bureau staff participated in parent empowerment programs sponsored by the Family Ties organization regarding "navigating the benefits system". Grass roots organizations collaborated to promote improved systems statewide, and influenced community agencies to collaborate on a formal plan for the state.

Family Ties staff participated in the Bureau's MCH Needs assessment and interacted with program staff. Meetings clarified areas in which families become frustrated within state systems, and helped in identifying areas of state systems that need improvement. This open exchange helped each side to gain a greater understanding of the other's situation and gain insights into how to best achieve goals that work for both.

The Bureau worked with parent and advocacy groups. Activities included meetings and panel discussions with consumers in both Reno and Las Vegas to discuss the scope of services covered by Title V programs, as well as develop linkages with other agencies such as Medicaid, Nevada Check Up, Shriner's and the Department of Education, for access to, and coordination of services.

The SHD was awarded a Centers for Medicare and Medicaid Services "Real Choice Systems Change" grant that provides needed resources to assess and assure family participation in decision making for CSHCN. A program manager, a management analyst, and clerical support

were hired and immediately moved forward in putting out a "Request for Proposal" for a contractor to perform a statewide needs assessment of the strengths, weaknesses and gaps in service in Nevada's system of care for CSHCN. The Family Ties representative was a part of the evaluation team. The RCSC grant staff were active in partnering with groups such as Medicaid's Continuum of Care office, Mental Health, E.I.Services, Office of Disability Services, Vocational Rehabilitation, Department of Education - Special Education, the Transition Forum - a subcommittee of the Governor's task force and County School Districts. All of these agencies and consumers were involved in the development of the Real Systems Change grant application, and continue to be involved as it is implemented.

The SHD hired a vendor to complete a needs assissment of Nevada's system of long term services and supports for CSHCN and their families. Major needs identified were: a) a difficult and cumbersome financial assistance eligibility process and b) lack of access to services including marginal availability of qualified service providers, physicians, and specialists. Activities are currently being refined to address these two priorities during the one-year demonstration project.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Per the national CSHCN survey, 54.6% of Nevada families partner in decision making at all levels and are satisfied with the services they receive.		X		
2. Staff will continue to strengthen existing relationships with Family Ties and Early Intervention Services and continues to collaborate with the new partners in the office of Disability Services, Mental Health, Special Education and the County School				X
3. Family Ties, Nevada PEP and CSHCN staff continue to provide cross referral for services.		X		X
4. The Nevada Children with Special Health Care Needs Assessment identified the prevailing needs as improvements in the financial application process and the lack of all provider types.		X		X
5. The Nevada Advisory Council on CSHCN, will oversee and direct the activities of the three pilot projects in Reno, Las Vegas and Elko.		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

NPM # 2: FY 06. Staff will continue to strengthen existing relationships with Family Ties and Early Intervention Services and continues to collaborate with the new partners in the office of Disability Services, Mental Health, Special Education and the County School Districts. These established and new links will be active participants in the RCSC grant needs assessment. Activities directed toward linking Family Ties representatives and E.I. staff will continue. The Bureau staff continues to work on establishing Family Ties representation at the E.I. clinics to better empower families in choosing appropriate services for their child. They will partner with the Resource Parents already in place. Family Ties and CSHCN staff continue to provide cross referral for services. Family Ties information and referrals forms continue to be sent to families applying for CSHCN, and Family Ties readily refers to CSHCN.

The Nevada Advisory Council on CSHCN met, and advised the CSHCN program on pilot development. This group membership includes two-thirds parents and one-third providers. The Nevada Children with Special Health Care Needs Assessment was completed. Parents were an important component of the focus groups utilized during the needs assessment process. The information will form the basis for three pilot projects (funded by the RCSC grant) for systems change for CSHCN; the Council is very involved in their development and will oversee their implementation.

A CSHCN helpline survey was developed during the RCSC project. The evaluation team is an external contracted evaluator and worked with families, providers, university staff, and the Advisory Council for CSHCN to devleop the survey. Respondents are recruited from callers to the state's toll free CSHCN helpline. Only a small number of respondents were recruited to pilot the survey. It is a tested instrument ready to be used for continued data collection. In addition, staff have documentation (based on billing records) to report the number of calls to the helpline indicating change in volume and a log prepared by the helpline operators to indicate the nature of the call and how the caller learned about the helpline.

c. Plan for the Coming Year

NPM # 2: FY 07. The Nevada Children with Special Health Care Needs Assessment identified the prevailing needs as improvements in the financial application process and the lack of all provider types. These issues will be addressed by the Nevada Advisory Council on CSHCN, which will oversee and direct the activities of the three pilot projects in Reno, Las Vegas and Elko.

Plans are to continue to strengthen existing ties with Family Ties, Early Intervention Services, Disability Services, Mental Health, Special Education and all of the urban and rural school districts, as well as various community agencies statewide to improve access to services for CSHCN.

The helpline survey will continue as will collection of helpline data.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			50	55	55
Annual Indicator		49.1	49.1	49.1	49.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	55	55	57	59	61

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

The Real Choice Systems Change grant is being actively implemented. Linkages of CSHCN with physicians, and community programs are being developed to improve access to a medical home and coordination of services. Thus, it is anticipated that this percentage will slowly grow.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
NPM # 3:FY 05: (SLAITS data, which will not change until the study is updated) 49.1. See also State priority 5.

The Nevada CSHCN program was only able to specifically track and analyze the status of those CSHCN who are either eligible for assistance with payment of their treatment and other services, and/or seen at the multidisciplinary medical specialty clinics. Thus data from the national survey of CSHCN is being used as a base.

The CSHCN program encouraged families to have a "medical home" or "primary care provider" (PCP). Families were asked who the child's PCP is, and the program covered quarterly visits to the PCP if the child's condition remained stable, however, the program does require at least an annual visit with the subspecialist. This encouraged families to continue coordinated services for the optimum well being of their child. Since most of the PCP's for this population are Board Certified Pediatricians, they have embraced this policy and have willingly assumed this responsibility as it has enhanced their ability to see the patient on a continued basis. If a family does not have a PCP, staff works with the family to find an appropriate PCP. PCP's often call CSHCN staff to seek assistance with accessing needed resources. CSHCN staff monitor cases for Medicaid and Nevada Check Up eligibility.

Medicaid and Nevada Check Up programs mandated managed care in the urban areas of the state; in FY 04 a second HMO was added in the north, so managed care is mandated there too. A majority of CSHCN on these programs should have a medical home.

Since the beginning of 2004, the MCH Campaign has been in place and its multi-media component encouraged families to seek a medical home for their children and provide public health education on the value of primary and preventive care. Callers to the IRL for pediatric information were referred to Medicaid and Nevada Check Up for coverage of care and to pediatric providers in their community. Providers who have signed up for the MCH campaign also agreed to see infants and children regardless of a family's ability to pay. Sliding and/or discounted fee schedules have been established for cash-pay clients. The MCH campaign includes a Pediatric outreach campaign.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCN and RCSC staff works with Medicaid and Nevada Check Up to develop ways of increasing the number of children eligible for and receiving EPSDT preventive examinations and received HRSA technical assistance to increase the use of EPSDT.		X		X
2. The Real Choice Systems Change grant and needs assessment provided needed support to identify data sources that expand to all children, as well as provided state planners				X

with useful information to determine where increased efforts need to be.				
3. A multi-media campaign encourages families to seek a medical home for their children and provides public health education on the value of primary and preventive care.		X		X
4. The CSHCN program continues to establish and cover a PCP for those children who are on the program.	X	X		
5. RCSC team supported Family Ties proposal for medical home technical assistance.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

NPM # 3: FY06. A goal of the RCSC grant is to increase the EPSDT rate for CSHCN on Medicaid and encourage a medical home. Staff is working with Medicaid and Nevada Check Up to develop ways of increasing the number of children eligible for and receiving these preventive examinations. The RCSC grant and the needs assessment provided needed support to identify data sources that expand to all children, as well as provided state planners with useful information to determine where increased efforts need to be focused.

Since many Medicaid/Nevada Check Up eligible children are enrolled in managed care organizations, medical home data is available through claims records for services delivered through Medicaid and Title XXI claims records. Clear data is still not readily available as the Medicaid program has been in the process of getting certification for its data system, and it is uncertain whether data on CSHCN children enrolled in their program is available.

The MCH Campaign is a source of information for families. This multi-media component encourages families to seek a medical home for their children and provides public health education on the value of primary and preventive care. The multi-media campaign is using Bright Futures to guide the content of the multi-media campaign. Callers to the IRL for pediatric information continue to be referred to Medicaid and Nevada Check Up for coverage of care and to pediatric providers in their community. Providers who have signed up for the MCH Campaign agreed to continue to see children, including infants, regardless of a family's ability to pay. Sliding and/or discounted fee schedules have been established for cash-pay clients. The CSHCN program continues to establish and cover a PCP for those children who are on the program.

A goal of the RCSC grant and its pilots is to ensure a medical home for all CSHCN in Nevada. The Nevada CSHCN needs assessment documented resources and gaps in primary, mental and dental care as well as specialty care. A medical home physician's survey was developed during the RCSC project. The evaluation team is an external contracted evaluator who worked with physicians, providers, university staff, and the multi-disciplinary CSHCN evaluation group to develop the survey. It is derived from the Center for Medical Home Improvement's Medical Home Index by W. Carl Cooley, MD, Jeanne W. McAllister, RN, MS, MHA, Kathleen Sherrieb, RN, MS, MPH, and Robin E. Clark, PhD (2002). The Nevada Medical Home survey is being sent to 400 Advanced Practice Nurses (APNs) and 500 Primary Care Physicians. This is an instrument that could be repeated in future years. Also from the same research group, a family's version of the Medical Home Index is available to supplement the physician's version. Administering both of the instruments in Nevada would more accurately record changes in the use and understanding of the medical home concept for CSHCN.

c. Plan for the Coming Year

NPM # 3: FY07. Since one of the goals of the Real Choice Systems Change grant is to increase the EPSDT rate for CSHCN on Medicaid, staff will continue to work with Medicaid to develop ways of increasing the number of children eligible for and receiving these preventive examinations. Staff will continue to work with Nevada Check Up to develop a system of tracking and reporting "well child" examinations on eligible children enrolled RCSC grant will provide needed support to identify and develop data sources that include all children, and provide state planners with useful information to determine where increased efforts need to be focused. RCSC has requested and will receive Technical Assistance to hold a meeting around EPSDT in the coming year.

A goal of the RCSC grant is to ensure a medical home for all CSHCN in Nevada. The Nevada Children with Special Health Care needs assessment documented resources and gaps in primary, mental and dental care as well as specialty care that the Nevada Advisory Council on CSHCN will address via pilot projects. The APN and physican survey noted in the current year will continue in the coming year.

The MCH Campaign continues to be a source of information for families. The multi-media component will continue to encourage families to seek a medical home for their children and provides public health education on the value of primary and preventive care. Callers to the IRL for pediatric information will continue to be referred to Medicaid and Nevada Check Up for coverage of care and to pediatric providers in their community. Providers who have signed up for the MCH Campaign have also agreed to continue to see children, including infants, regardless of a family's ability to pay. Sliding and/or discounted fee schedules have been established for cash-pay clients and will continue.

The CSHCN program will continue to establish and cover a PCP for those children who are on the program.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			56	58	60
Annual Indicator		55.4	55.4	55.4	55.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	62	64	66	68	70

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments

a. Last Year's Accomplishments
NPM # 4: FY 05. (SLAITS data, which will not change until SLAITS is updated) 55.4. See also State priority 5.

HD staff worked with staff from Medicaid and Nevada Check Up to more clearly identify CSHCN in all programs. This increased awareness of the need for identifying children with special needs throughout the state has encouraged closer cooperation between agencies and enhanced sharing of available data.

CSHCN staff assisted families in applying for Medicaid and Nevada Check Up by providing information, referral and assistance through the process. CSHCN staff also provided advocacy for families with private insurance in providing medical information, especially for rare disorders, in order to justify the need for specific services and supplies.

The MCH information line has been a primary component for signing up infants and children for Medicaid and Nevada Check Up. All who call are queried regarding their insurance status. If they have concerns about it, staff will refer them to Medicaid and/or Nevada Check Up and other resources such as the members of Great Basin Primary Care Association (GBPCA). The CSHCN program was also a referral source for Medicaid and Nevada Check Up, as well as for SSI for the CSHCN.

The Real Choice Project Team collaborated with the Covering Kids program for a joint media campaign in association with the Nevada Broadcaster's Association (NBA). Covering Kids is a grant funded program housed in the Division of Health Care Financing and Policy (DHCFP). The program's goal is to reduce the number of uninsured children who are eligible for public health care coverage programs - but not enrolled. The media campaign's goals were to increase awareness of available state programs for all children, including those with special needs. The campaign also promoted the Healthy Kids (EPSDT) program and the services available through the CSHCN program. The campaign was guided by a contracted media professional who is also Nevada's Family Voices coordinator and director of Family Ties, a parent-driven group which provides training, information, and emotional support for CSHCN and their families.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Per the national CSHCN survey, 55.4% of Nevada families have adequate private and/or public insurance to pay for the services they need.				X
2. CSHCN staff continued to assist families in applying for Medicaid and Nevada Check Up by providing information and referral to appropriate programs and community resources.		X		
3. CSHCN staff provided advocacy for families with private insurance by providing medical information (especially for rare disorders), in order to justify the need and coverage for specific services and supplies.		X		X
4. The MCH information line and the CSHCN program continues as a referral source for Medicaid and Nevada Check Up, as well as for SSI for the CSHCN.		X		X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

NPM # 4: FY 06. CSHCN staff continued to assist families in applying for Medicaid and Nevada Check Up by providing information and referral to appropriate programs and community resources. Assistance through the process and advocacy for service coverage was also provided to those with private insurance, as well as government programs. CSHCN staff provided advocacy for families with private insurance by providing medical information (especially for rare disorders), in order to justify the need and coverage for specific services and supplies. CSHCN staff continued to refer potentially eligible families to Medicaid, SSI, and Nevada Check Up, and followed them until an eligibility determination was made.

The MCH information line continues to be a primary component for signing up infants and children for Medicaid and Nevada Check Up. All callers were queried regarding their insurance status. If they did not have coverage, staff refered them to Medicaid and/or Nevada Check Up and other resources such as the members of GBPCA. The MCH information line and the CSHCN program continues as a referral source for Medicaid and Nevada Check Up, as well as for SSI for the CSHCN.

The CSHCN program worked with Nevada Medicaid and Nevada Check Up to increase the number of CSHCN who received an EPSDT examination for their child. Nevada Check Up does not have an "EPSDT" exam in place, but does cover "well child" examinations. Nevada Check Up staff reported that the program does not currently have the necessary resources to initiate a system to track "EPSDT" exams or "well child" exams. They are only able to track "any service" of any type. CSHCN staff is working with Nevada Check Up to develop a means of tracking this type of data in their program.

The Bureau experienced a drop in caseload most likely due to changes in Medicaid when the asset test was dropped in July 1, 2004, and more children became eligible for Medicaid.

c. Plan for the Coming Year

Plan for the coming year

NPM # 4: FY 07. CSHCN staff continued to assist families in applying for Medicaid and Nevada Check Up by providing information and referral to appropriate programs and community resources. Assistance through the process and advocacy for service coverage was also provided to those with private insurance, as well as government programs. CSHCN staff provided advocacy for families with private insurance by providing medical information (especially for rare disorders), in order to justify the need and coverage for specific services and supplies. CSHCN staff continued to refer potentially eligible families to Medicaid, SSI, and Nevada Check Up, and followed them until an eligibility determination was made.

The MCH information line continues to be a primary component for signing up infants and children for Medicaid and Nevada Check Up. All callers were queried regarding their insurance status. If they did not have coverage, staff refered them to Medicaid and/or Nevada Check Up and other resources such as the members of GBPCA. The MCH information line and the CSHCN program continues as a referral source for Medicaid and Nevada Check Up, as well as for SSI for the CSHCN.

The CSHCN program worked with Nevada Medicaid and Nevada Check Up to increase the

number of CSHCN who received an EPSDT examination for their child. Nevada Check Up does not have an "EPSDT" exam in place, but does cover "well child" examinations. Nevada Check Up staff reported that the program does not currently have the necessary resources to initiate a system to track "EPSDT" exams or "well child" exams. They are only able to track "any service" of any type. CSHCN staff is working with Nevada Check Up to develop a means of tracking this type of data in their program.

The Bureau experienced a drop in caseload most likely due to changes in Medicaid when the asset test was dropped in July 1, 2004, and more children became eligible for Medicaid. In addition, staff has become more proficient in appropriate referral and advocacy for client eligibility for both Title XIX and Titl XXI services.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			75	78	80
Annual Indicator		75.1	75.1	75.1	75.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	82	85	86	87	88

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
NPM # 5: FY 05. (SLAITS data, which will not change until the study is updated) 75.1

CSHCN staff provided information and advocacy to families and providers attempting to access community-based services. CSHCN staff maintained current information regarding eligibility criteria, asset test criteria, and medical criteria for a variety of programs including Medicaid, Nevada Check Up , Food stamps, WIC, Federally Qualified Health Centers, mental health services, and community organizations. This allowed them to serve as a 'data bank' of information for families in need of high quality, but often expensive, medical care. CSHCN staff also maintained contact with organizations such as the Shriner's in order to provide appropriate referrals and assist with ancillary services as needed. The CSHCN Program collaborated with the Bureau of Early Intervention Services (BEIS) to develop improved procedures for referral and linkage to other government programs and community groups.

Staff continually updated lists of local providers of pharmacy, durable medical equipment, supplies and transportation to assist families with needed services, and was actively involved with arranging for connecting families with appropriate volunteer organizations to receive assistance with "uncovered" services such as lodging, transportation, and "new types of equipment" that are often not covered by most insurance. E.I interdisciplinary clinic staff provided a multi-disciplinary evaluation and referrals to appropriate medical, social and mental health services, as well as referrals for community programs including CSHCN.

Staff also provided training to parent groups to assist them in accessing programs and services. The Family Ties program conducted parent training for families of CSHCN. Staff also met with BEIS and Community Health Nurse staff to discuss the CSHCN program and clarify the services provided. CSHCN staff provided input to parents on how to best "navigate the system" through contact with parent advocacy groups and individual parents. This has proved to be a most satisfying experience on both sides. As a result, families and family organizations are initiating increased contact with CSHCN staff with requests for information.

Staff was hired for the Real Choice Systems Change (RCSC)grant and they immediately set about drafting a "Request for Proposal" for a statewide needs assessment, which was completed. RCSC staff have also connected with representatives of Medicaid, Nevada Check Up, E.I., Mental Health, Office of Disability Services, Vocational Rehabilitation, Department of Education-Special Education, and local County school districts.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Per the national CSHCN survey, 75.1% of families report the community-based service systems are organized so they can use them easily.		X		X
2. CSHCN staff continued to assist families in applying for Medicaid and Nevada Check Up by providing information and referral to appropriate programs and community resources.		X		
3. The MCH information line continues to be a primary component for signing up infants and children for Medicaid and Nevada Check Up. All callers were queried regarding their insurance status.		X		X
4. Assistance through the process and advocacy for service coverage will also be provided to those with private insurance, as well as government programs.		X		
5. The CSHCN program will work with Nevada Medicaid and Nevada Check Up to increase the number and tracking capacity of CSHCN who receive an EPSDT, or "well child" examination for their child.		X		X
6. RCSC team support and cross referral to the Nevada 2-1-1 information and referral system.		X		X
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

NPM # 5: FY 06. CSHCN staff continued to assist families in applying for Medicaid and Nevada

Check Up by providing information and referral to appropriate programs and community resources. Assistance through the process and advocacy for service coverage was also provided to those with private insurance, as well as government programs. CSHCN staff provided advocacy for families with private insurance by providing medical information (especially for rare disorders), in order to justify the need and coverage for specific services and supplies. CSHCN staff continued to refer potentially eligible families to Medicaid, SSI, and Nevada Check Up, and followed them until an eligibility determination was made.

The MCH information line continues to be a primary component for signing up infants and children for Medicaid and Nevada Check Up. All callers were queried regarding their insurance status. If they did not have coverage, staff refered them to Medicaid and/or Nevada Check Up and other resources such as the members of GBPCA. The MCH information line and the CSHCN program continues as a referral source for Medicaid and Nevada Check Up, as well as for SSI for the CSHCN.

The CSHCN program worked with Nevada Medicaid and Nevada Check Up to increase the number of CSHCN who received an EPSDT examination for their child. Nevada Check Up does not have an "EPSDT" exam in place, but does cover "well child" examinations. Nevada Check Up staff reported that the program does not currently have the necessary resources to initiate a system to track "EPSDT" exams or "well child" exams. They are only able to track "any service" of any type. CSHCN staff is working with Nevada Check Up to develop a means of tracking this type of data in their program.

The Bureau experienced a drop in caseload most likely due to changes in Medicaid when the asset test was dropped in July 1, 2004, and more children became eligible for Medicaid.

c. Plan for the Coming Year

c. Plan for the Coming Year

NPM # 5: FY 07. CSHCN staff will continue to assist families in applying for Medicaid and Nevada Check Up by providing information and referral to appropriate programs and community resources. Assistance through the process and advocacy for service coverage will also be provided to those with private insurance, as well as government programs. Staff will continue to provide advocacy for families with private insurance in providing medical information, especially for rare disorders, in order to justify the need for and coverage of specific services and supplies. CSHCN staff will continue to refer potentially eligible families to Medicaid, SSI, and Nevada Check Up, and follow them until eligibility determination has been made, while providing technical assistance to assure accurate case determination.

The MCH information line will continue to be a primary component for signing up infants and children for Medicaid and Nevada Check Up. All callers are queried regarding their insurance status. If they do not have coverage, staff will refer them to Medicaid and/or Nevada Check Up and other resources such as the members of GBPCA. If the family does have insurance, CSHCN staff provide valuable assistance via information regarding rare disorders, and medical justification for specialized services and supplies. The MCH information line and the CSHCN program will continue as a referral source for Medicaid and Nevada Check Up, as well as for SSI for the CSHCN.

The CSHCN program will work with Nevada Medicaid and Nevada Check Up to increase the number and tracking capacity of CSHCN who receive an EPSDT, or "well child" examination for their child. Since Medicaid has the capacity to track this data, CSHCN will request an annual report. CSHCN staff will continue to work with Nevada Check Up to develop a means of tracking this type of data in their program.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			6	10	5.8
Annual Indicator		5.8	5.8	5.8	11
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	12	15	20	25	27

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure. This data is SLAITS data that the State has no control over.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

The Real Choice Systems Chang grant is being implemented and various parent groups and community agencies are working together to develop and improve transition services statewide. Staff is working with the Department of Education and parents to provide technical assistance. In addition, staff has developed a web-site and participates in local publications to educate the public about available services. Thus, we anticipate gradual improvement in this area.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
NPM # 6: FY 05. (SLAITS data, which will not change until the study is updated) 5.8. See also State priority 5.

CSHCN staff provided information and advocacy to families and providers attempting to access community-based services. CSHCN staff maintained current information regarding eligibility criteria, asset test criteria, and medical criteria for a variety of programs including Medicaid, Nevada Check Up , Food stamps, WIC, Federally Qualified Health Centers, mental health services, and community organizations. This allowed them to serve as a 'data bank' of information for families in need of high quality, but often expensive, medical care. CSHCN staff also maintained contact with organizations such as the Shriner's in order to provide appropriate referrals and assist with ancillary services as needed. The CSHCN Program collaborated with the Bureau of Early Intervention Services (BEIS) to develop improved procedures for referral and linkage to other government programs and community groups.

Staff continually updated lists of local providers of pharmacy, durable medical equipment, supplies and transportation to assist families with needed services, and was actively involved with arranging for connecting families with appropriate volunteer organizations to receive assistance with "uncovered" services such as lodging, transportation, and "new types of equipment" that are often not covered by most insurance. E.I interdisciplinary clinic staff provided a multi-disciplinary evaluation and referrals to appropriate medical, social and mental health services, as well as

referrals for community programs including CSHCN.

Staff also provided training to parent groups to assist them in accessing programs and services. The Family Ties program conducted parent training for families of CSHCN. Staff also met with BEIS and Community Health Nurse staff to discuss the CSHCN program and clarify the services provided. CSHCN staff provided input to parents on how to best "navigate the system" through contact with parent advocacy groups and individual parents. This has proved to be a most satisfying experience on both sides. As a result, families and family organizations are initiating increased contact with CSHCN staff with requests for information.

Staff was hired for the Real Choice Systems Change (RCSC)grant and they immediately set about drafting a "Request for Proposal" for a statewide needs assessment, which was completed. RCSC staff have also connected with representatives of Medicaid, Nevada Check Up, E.I., Mental Health, Office of Disability Services, Vocational Rehabilitation, Department of Education-Special Education, and local County school districts.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCN counsels parents regarding having PCP assist with referral to adult health care providers.	X	X		
2. CSHCN provides information for families regarding SSI eligiblity, Medicaid eligibility, etc.		X		
3. CSHCN provides family information regarding IEP for appropriate vocational training of CSHCN.	X	X		
4. CSHCN encourages families to be involved with the educational plan for their child.	X	X		
5. PCP and families are given information on adult providers to work with specific conditions.	X	X		
6. PCP and families are given information where in community ancillary services may be available.	X	X		
7. RCSC works with the Office of Disability Services to ensure an action plan for the transition of CSHCN to adult services is created.			X	
8. CSHCN program manager trained attendees at the Family TIES' Youth Health Transitioning Training		X		
9.				
10.				

b. Current Activities

b. Current Activities

NPM # 6: FY06. CSHCN staff provide information and advocacy to families and providers attempting to access community-based services. CSHCN staff updates current lists of local providers for pharmacy, durable medical equipment, supplies, transportation, and lists of local volunteer organizations to access assistance with "uncovered" services such as lodging, transportation and "new types of equipment" that are often not covered by most insurance. CSHCN staff updates information on eligibility criteria for Medicaid, Nevada Check Up, Food Stamps, WIC, Shriner's, Federall Qualified Health Centers, and community organizations in order to provide appropriate referrals and ancillary services as needed.

The SHD was awarded a "Real Choice Systems Change" (RCSC) grant by the Centers for Medicare and Medicaid. This funding supported a statewide needs assessment of the current

systems of care for CSHCN, which was completed in January 2005. The RCSC grant supported needs assessment provides a clear outline of gaps in service for CSHCN. State planners are now able to more clearly define areas of "non availability" or "non coverage" as well as those areas of the state lacking or duplicating services. Rural areas of the State are, of course, among the most needy of services, but defining where and what services exist/or are needed, is a real start in solving the problems. The Nevada Advisory Council on CSHCN is bringing together all those stakeholders involved with this population, and will allow for creative solutions to be developed. To attain the broadest degree of stakeholder involvement, the Council includes family members of CSHCN and disabilities advocates from across the state.

The Council is reviewing the needs assessment report, is considering areas of priority, and has decision making responsibilities in the direction and content of project activities.

c. Plan for the Coming Year

c. Plan for the coming year

NPM # 6: FY07. Plans for the coming year are to continue the activities started in the current year. The RCSC grant ends September 29th; staff previously supported by the CMS grant have been moved to the MCH Block Grant to continue the systems development activities. The partnership with the Office of Disability Services will be particularly important in addressing transitioning of CSHCN to adulthood.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	78	79	78	75	75
Annual Indicator	66.0	74.4	74.4	74.5	66.7
Numerator	28692	33307		31160	
Denominator	43473	44768		41826	
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	70	72	75	77	80

Notes - 2005

This data is from CDC for 2005 data.

Notes - 2003

This data comes from the CDC produced National Immunization Survey for Nevada for 7/2/2002 - 6/30/03. The numerator and denominator were not given.This data was given to the Bureau by the State's Immunization Program.

a. Last Year's Accomplishments

NPM # 7. Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B. FY 04: 74.5

Reporting of this measure is from the CDC's National Immunization Survey for Nevada for children. The latest data is from 2004. This goal is always impacted by the state's rapidly growing population and ever increasing birth rate. This measure is a population based service

that targets infants and young children. Although this National Performance Measure is reported to age 35 months, the initiative itself serves older children including those to age 5 in the WIC program. This measure is population based.

MCH funding supported immunizations offered in Bureau of Community Health community health nursing clinics.

There is a very strong link between Nevada's Immunization (in BCH) and WIC programs. In 2005 WIC downloaded a listing of all children 2 years of age and younger for the Immunization Program Manager who compared the names to those on WEBIZ, the state's immunization registry. With this data it became clear that WIC clinics are not asking for the immunization status of their clients. This was discussed at the annual meeting of WIC agency's Directors and all agreed that more effort could be made to promote immunizations in WIC children. Planned work on linking WIC clinics with WEBIZ did not take place primarily due to resource issues.

The MCH hot line at 1-800-429-2669 provided callers on information on where to obtain immunizations for their children.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Immunization Subcommittee of the MCHAB will continue to work with the Immunization Program, seeking ways to implement best practices in MCHsupported initiatives.		X	X	
2. Referral of callers to the MCH Campaign Line to immunization resources will continue.		X		
3. Continue funding Community Health Nursing Services which include immunizations.		X		
4. Continue developing WIC clinic linkage with the State Immunization program and target those clinics with low immunization rates.		X		
5. Imclude information on immunizations with that given to women and their infants served by the MCH Campaign.		X		
6. Investigate including immunization information on WIC Electronic Benefit Transfer cards and tying them to the Immunization Registry.			X	
7.				
8.				
9.				
10.				

b. Current Activities

NPM # 7: FY 06. Activities in FY 06 focused on exploring ways to bring up Nevada's Immunization rates. Due to the state ranking 50th in the Nation, Health Division Administration directed the Bureau to get more involved with the Immunization program and seek ways to assist with addressing the problem. In response a Subcommittee of the Maternal and Child Health Advisory Board was convened. Included on the Subcommittee are representatives of the Health Districts, the 2 legislators, and other interested individuals who have a stake in promoting immunizations. In this year the Immunization Program (in the Bureau of Community Health) also obtained a CDC consultant for Immunizations who began the process of revitalizing the program, leading to a bit of a discussion between the Bureau and the program over who is going to do what that is ongoing. In April 2005 the CDC consultant held a stakeholders meeting that all interested in the issue attended, aimed at collecting information on what is happening around immunizations

in Nevada and developing an Action plan. This plan is in process.

MCH funding supports immunizations offered in the BCH community health nursing clinics as well as in the MCH supported Washoe County District Health Department clinics.

The Bureau continues to maintain a maternal and child health information and referral line, which is staffed by a bilingual operator. Callers requesting information about immunizations are referred to local clinics that give immunizations in their area. This information is being kept updated by the Immunization Program.

The 2005 Legislature passed a bill requiring the Division of Health Care Financing and Policy (DHCFP) to require that each dependent child for whom a recipient is receiving assistance (defined to include Medicaid, Food Stamps, TANF and the program for Child Care and Development) has received the standard immunizations required by NRS, and that by six months after determination of eligibility proof of such immunizations much be submitted to the Division (DHCFP). The MCHAB is receiving regular updates on the implementation of this requirement and dialoging with Medicaid in particular on it.

c. Plan for the Coming Year

NPM # 7: FY 07. Activities begun in FY06 will continue into FY07. The MCHAB will consider the future of its Subcommittee at its summer meeting. The Immunization Action Plan will be completed. The MCHAB Subcommittee will look to identifying pockets of need for special attention. It will look at immunizations within the broader context of child health and tie it into a report on the health of children and adolescents in Nevada being prepared by Bureau staff. This includes looking at the health of children as it relates to vaccine preventable diseases, and use of the MCH Campaign to promote vaccine sites.

The Bureau will also continue to work with the Immunization Program to seek ways to partner in promoting best immunization practices. The match in FY06 of WIC and WEB IZ (the Immunization Program's Immunization Registry) indicated that WIC children are immunized at a lower rate than the general population. This information will be used in FY07 to target those WIC clinics whose immunization rates are low. The Immunization Program is making a great effort to vitalize WEB IZ; there is a chance it will be placed in WIC clinics so that WIC staff can check immunization status at certification and make necessary referrals. The Bureau is also looking to co-locate with Community Health Nursing offices which would facilitate accessing immunizations.

Finally, the CHSCN Program is working with Medicaid to promote Early Periodic Screening, Diagnosis and Treatment (EPSDT) in the Medicaid population. Immunizations should be a part of an EPSDT exam if needed.

The high cost of vaccines forces Nevada to limit distribution of free vaccine to only those providers who see children that qualify for the federal Vaccines for Children Program. There is a possibility that vaccines will be a topic of discussion in the 2007 Legislature, and state funding appropriated.

WIC is looking for additional partners for its Electronic Benefits Transfer (EBT) Card. Immunizations is one of them. This will be looked at very seriously in FY07 as efforts to expand EBT statewide continue.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	34	33	30	27	26
Annual Indicator	30.6	27.1	27.5	26.7	25.9
Numerator	1214	1174	1257	1266	1330
Denominator	39689	43328	45749	47362	51274
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	25	24	24	24	23

a. Last Year's Accomplishments
Data reported for this performance measure comes from the CHDR, birth certificates. This is preliminary data. This measure is a population based measure. FY 05: 26.8 (see also SPM 4).

The main activities for Nevada's teen pregnancy prevention initiative included community involvement through community organizations, the Nevada Statewide Coalition Partnership, which is a network of prevention coalitions located in ten of Nevada's seventeen counties, and the continuation of the Governor's Youth Advisory Council, which has identified teen pregnancy prevention as one of its top three priorities.

The majority of Nevada's abstinence education funds were made available to the community organizations through subgrants via an RFP process. These funds were targeted towards the Hispanic/Latino populations of Clark and Washoe counties which are the state's most populous counties with the highest rates of teen births.

Some funds were also used to promote parental communication and connectedness throughout the State. Two subgrants provided education for parents in the various issues of teen maturation and how to talk to their children about abstinence. Positive Choices, Positive Futures was a popular program in Clark County as the Area Health Education Center of Southern Nevada continued to be successful in marketing it. An attempt to replicate the program in Northern Nevada was explored.

Materials in the Teen Pregnancy Prevention Resource Center were made available to community organizations and other interested parties upon request. The State Health Division maintained the State Teen Pregnancy Prevention website: http://health2k.state.nv.us/CAH/teenpregprevention.htm, which offers resources to the public.

Bureau staff continued to seek other opportunities to work collaboratively with various communities within communities that can include racial/ethnic groups, migrant families, youth with special health care needs, youth in foster care, and run away and homeless youth. It established a connection with the new State Minority Health Officer, who is based in Las Vegas, for assistance with this initiative.

The abstinence education media campaign with Nevada Broadcasters Association began again in late FY 05.

The Governor's Youth Advisory Council (GYAC) continued their "Abstinence Works!" presentations on a limited basis. The GYAC along with the Abstinence Education Program staff evaluated the program and decided to not continue it any longer. It remained undetermined how much impact a one hour classroom presentation would have on behavior.

Bureau staff, the MCH Advisory Board, and the GYAC worked with the Clark County School District, the fifth largest school district in the United States, to improve their sex education curriculum. The Bureau, through the Abstinence Grant, provided updated educational media and materials to the school district. This group continued to look at ways to support the training of

school administrators and staff.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Governor's Youth Advisory Council's continued commitment to teen pregnancy prevention via keeping TPP as one of their top priorities.			X	
2. Continued support of community coalitions and organizations (including ones emphasizing minority populations) by making federal abstinence education funds available for subgrants for abstinence education and developing partnerships with the GYAC.		X		
3. Continuation of a statewide media campaign with Nevada Broadcasters Association promoting sexual abstinence.			X	
4. Continue supporting workshops for parents of adolescents teaching them the importance of healthy sexuality.		X		
5. Development and implementation of teen pregnancy prevention programs specifically targeting the Hispanic/Latina populations in Washoe and Clark Counties.		X		
6. Continue maintenance of TPP webpage and resource center.			X	
7. Continue supporting teen health clinics in Washoe and Clark Counties.		X		
8. Continue supporting local school districts throughout Nevada, especially Clark County which is the fifth largest school district in the Nation.		X		
9. Continue monitoring teen pregnancy prevention data to determine success of interventions, needed changes to the program, and direct best use of funds.				X
10.				

b. Current Activities

The main activities for Nevada's teen pregnancy prevention initiative include community involvement through community organizations, the Nevada Statewide Coalition Partnership, which is a network of prevention coalitions located in ten of Nevada's seventeen counties, and the continuation of the Governor's Youth Advisory Council, which has identified teen pregnancy prevention as one of its top three priorities.

The majority of Nevada's abstinence education funds are made available to the community organizations through subgrants via an RFP process. Two of the established subgrants continue in 2006 and are targeted towards the Hispanic/Latino populations of Clark and Washoe counties which are the state's most populous counties with the highest rates of teen births. These subgrants will conclude at the end of FFY 06.

Some funds are also used to promote parental communication and connectedness throughout the State. Two subgrants provide education for parents in the various issues of teen maturation and how to talk to their children about abstinence. Positive Choices, Positive Futures is a popular program in Clark County as the Area Health Education Center of Southern Nevada continued to be successful in marketing it. An attempt to replicate the program in Northern Nevada was established and is managed by the Washoe County District Health Department.

Materials in the Teen Pregnancy Prevention Resource Center are available to community organizations and other interested parties upon request. The State Health Division maintains the

State Teen Pregnancy Prevention website:
http://health2k.state.nv.us/CAH/teenpregprevention.htm, which offers resources to the public.

Bureau staff continues to seek other opportunities to work collaboratively with various communities within communities that can include racial/ethnic groups, migrant families, youth with special health care needs, youth in foster care, and run away and homeless youth.

The media campaign with Nevada Broadcasters Association continued in 2006. Six new radio non-commercial sustaining announcements (NCSA) have been created in English and are being translated into Spanish. Once completed the Spanish NCSAs will air throughout Nevada until the subgrant ends September 30, 2007.

Bureau staff and the MCH Advisory Board continue to work with the Clark County School District, the fifth largest school district in the United States, to improve their sex education curriculum. The Bureau, through the Abstinence Grant, provides updated educational media and materials to the school district, and has expanded to include materials for three additional school districts.

c. Plan for the Coming Year

The main activities for Nevada's teen pregnancy prevention initiative include community involvement through community organizations, the Nevada Statewide Coalition Partnership, which is a network of prevention coalitions located in 10 of Nevada's 17 counties, and the continuation of the Governor's Youth Advisory Council, which has identified teen pregnancy prevention as 1 of its top 3 priorities.

The majority of Nevada's abstinence education funds will continue to be made available to the community organizations through subgrants targeting Hispanic/Latino populations of Clark and Washoe. Specific areas of focus will be determined after adolescent birth data by county is reviewed.

Positive Choices, Positive Futures, a popular program in Clark County, will continue in Northern Nevada and will be managed by Washoe County District Health Department.

Materials in the Teen Pregnancy Prevention Resource Center will continue to be made available to community organizations and other interested parties upon request. The SHD maintains the State Teen Pregnancy Prevention website:
http://health2k.state.nv.us/CAH/teenpregprevention.htm, which offers resources to the public.

Bureau staff continues to seek other opportunities to work collaboratively with various communities within communities that can include racial/ethnic groups, migrant families, youth with special health care needs, youth in foster care, and run away and homeless youth. It has contacted the new State Minority Health Officer for assistance. He is based in Las Vegas.

The media campaign with Nevada Broadcasters Association will continue in FFY 07. Six radio non-commercial sustaining announcements (NCSA) were created in English and were translated into Spanish. Both the English and Spanish NCSAs will continue to air throughout Nevada until the subgrant ends September 30, 2007.

The Bureau, through the Abstinence Grant, will continue to provide updated educational media and materials to the 17 school districts throughout the State.

Bureau staff has requested a $400,000 budget enhancement for teen pregnancy prevention for the Health Division to build capacity for primary and secondary prevention of teen births. Funds would be used for a program in a community for teen pregnancy prevention utilizing an evidenced based positive youth development program, such as Straight Talk or Parenting Wisely. They

would also establish an Education Coordinator position within the Bureau of Community Health, who would coordinate with school and community health (urban and rural) nurses. In addition, funding for two existing teen health clinics would be increased, and an RFP for funding for a rural clinic would be run. This proposal will be considered by the Governor for inclusion in the Governor's Recommend budget, and hopefully ultimately by the 2007 Legislature. The state will have a new Governor by that time and it is unknown what support will be given to this enhancement at that time.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	41	42	43	38	38
Annual Indicator	37.5	37.5	32.5	32.5	33.0
Numerator	10760	11179			10350
Denominator	28693	29810			31364
Is the Data Provisional or Final?				Provisional	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	40	42	44	46	47

Notes - 2005
Children were not resurveyed in 2005. This is an estimate based on prior year.

Notes - 2004
This survey was not updated in 2004. The next screening is scheduled for FY 06.

Notes - 2003
This measurement is take from a statewide dental screening of third-graders conducted in 2003. The "Miles for Smiles" mobile dental bus and Saint Marys's "Take Care A Van" traveled to selected schools throughout the state to estimate sealant prevalence. A convenience sample was selected utilizing geographic diversity and socioeconomic status.

a. Last Year's Accomplishments
For FY 05, the percent was 33%. The numerator is the number of 3rd grade children with a sealant (10,350). The denominator is the number of 3rd grade children in the state during the year (31,364). Reporting of this measure is from a statewide dental screening of third-graders conducted in 2003 and estimated. (see also State priority 2 and SPM 2).

In 2005, there were 317 schools with a second grade in Nevada. School-based sealant programs were implemented in 58 of these schools (18%). The total number of second grade students, enrolled in Nevada schools during FY 05 was 31,376. There were 4,363 second grade students enrolled in schools with a school-based dental sealant program (14% of all second graders). The number of second grade students who had sealants placed in a school-based dental sealant programs was 2,019. The percent of children in schools with a school-based dental sealant programs who had sealants placed was 46.28%. The total number of sealants placed in school-based dental sealant programs in FY 05 was 7,056.

	FY 2000	FY 2001	FY2003	FY2004	FY2005
Annual Performance Objective	40	41	42	43	38
Annual Indicator	37.5	37.5	37.5	32.5	32.5
					(Final)

	FY 2006	FY 2007	FY2008	FY2009	FY2010
Annual Performance Objective	38	41	42	43	44
Annual Indicator					

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to collaborate with Saint Mary's, Community College of Southern Nevada, UNLV School of Dental Medicine and the Nevada Dental Hygienists' Association on the sealant program.		X		
2. Continue to identify target schools		X		X
3. Continue to schedule schools, volunteer dentists, dental students, dental hygienists and dental hygiene students.		X		
4. Continue to identify additional resources for the sealant program.		X		
5. Promote sealant placement by Medicaid and Nevada Check Up providers and by the private practice community.			X	
6. Continue to collect, analyze and report data on sealants.				X
7.				
8.				
9.				
10.				

b. Current Activities

In 2006, three school-based dental sealant programs are operating in Nevada. The Seal Nevada North program primarily targets schools in five counties in northeastern Nevada, the Seal Nevada South program primarily targets schools in Clark County, and the Saint Mary's Take Care-A-Van program primarily targets schools in Washoe County. The Health Division obtained a second year of funding ($65,000) from a HRSA State Oral Health Collaborative Systems grant to support the Seal Nevada North program ($25,000) and the Seal Nevada South program ($40,000). The Bureau also assisted the Seal Nevada South program with obtaining additional funding (approximately $10,000) from Oral Health America (OHA) through OHA's Smiles Across America, Las Vegas program. The Take Care-A-Van school-based dental sealant program is supported through donations and other grants obtained by Saint Mary's. Although the Bureau of Family Health Services does not provide direct financial support to Saint Mary's for operation of their school-based dental sealant program, Saint Mary's provides the Bureau with data from their program so that the Bureau can track sealant program data for the entire state. In addition, in 2006 the Bureau contracted with Saint Mary to collect data for a school-based dental sealant program cost benefit analysis.

The Bureau also convened a first time ever meeting of representatives from all three programs to share information and develop tools for process and outcome evaluation of school-based dental sealant programs. The MCH Block grant funds a half time position to coordinate school-based dental sealant programs and a Centers for Disease Control and Prevention (CDC) cooperative agreement funds a full-time position for oral health data analysis including collection and analysis of sealant data.

There was a 72% increase in the placement of sealants in FY2006 and a 77% increase in the number of children served.

c. Plan for the Coming Year
The SHD will continue to collaborate with Nevada Health Centers and the Community College of Southern Nevada in the Seal Nevada North and South programs. The SHD will continue to provide funding to operate the Seal Nevada programs through the HRSA State Oral Health Collaborative Systems grant and assist with coordination between schools and the programs. The SHD will continue to collect and analyze data from both Seal Nevada programs and from the Saint Mary's Take Care-A-Van program. In addition, the SHD may ask the 2007 Nevada Legislature for a budget enhancement ($100,000 a year) for establishment of new and expansion of existing school-based dental sealant program

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	4.2	4.2	3	2	2.5
Annual Indicator	2.3	2.8	4.3	4.0	2.5
Numerator	10	13	21	20	13
Denominator	432490	466923	483936	497677	526085
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	2.4	2.3	2.2	2	2

a. Last Year's Accomplishments
NPM # 10. The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. FY 05: 2.47. (see also State Priority 9. and SPM 6).

The data for FY 05 for this performance measure is from State vital statistics provided by the CHDR, Bureau of Health Planning and Statistics. This is preliminary data. This measure is a population-based measure that impacts children from birth through age 14.

The Nevada State Health Division's Injury Prevention Task Force oversees Nevada's injury prevention initiative. Members of the task force include: representatives from the Department of Education, Nevada Department of Transportation, the SHD BLC Emergency Medical Services (EMS), Bureau of Health Planning and Statistics, Southern Nevada Health District, Washoe County District Health Department, SAFE KIDS Clark County, SAFE KIDS Washoe County, Indian Health Services, Office of Suicide Prevention, and the Nevada Office of Traffic Safety.

The Injury Prevention Program is and will continue to collaborate with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, the Nevada Department of Public Safety, and the Nevada Office of Traffic Safety.

The Injury Prevention Program was involved in the Highway Safety Summit and the creation of the Nevada Traffic Safety Task Force. The Traffic Safety Task Force was organized by the Nevada Department of Transportation, and the goal of the Task Force is to address highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies that are committed to improving highway safety.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. The Injury Prevention Program performs data surveillance on Motor Vehicle Crashes of children aged 14 years and younger.				X
2. The Injury Prevention Program was involved in the Highway Safety Summit and the creation of Nevada's Executive Committee on Traffic Safety whose goal is to address highway safety in a comprehensive and coordinated manner.				X
3. The Injury Prevention Program is involved in the Child Passenger Safety Task Force. The purpose of the Task Force is to provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.			X	
4. The Injury Prevention Program is and will continue to collaborate with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, the Nevada Department of Public Safety, and the Office of Traffic Safety.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
NPM # 10: FY 06.

The Injury Prevention Program is involved in the Child Passenger Safety Task Force, which is a result of a recommendation made in the Occupant Protection for Children Assessment, and is organized by the Nevada Office of Traffic Safety. The Task Force meets monthly and its purpose is to provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.

The Injury Prevention Program is also involved in the Nevada Executive Committee on Traffic Safety. This Committee is organized by the Nevada Department of Transportation, and the goal of the is to address highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies that are committed to improving highway safety.

The Injury Prevention Program applied for and received funding through the Centers for Disease Control and Prevention to continue Nevada's Injury Prevention Program for five more years. The program will now be funded through July 31, 2010.

Motor vehicle crashes continue to be a priority of Nevada's Injury Prevention Task Force. The Task Force members will continue to collaborate on motor vehicle crash prevention efforts.

The Injury Prevention Program is and will continue to collaborate with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, the Nevada Department of Public Safety, and the Nevada Office of Traffic Safety.

c. Plan for the Coming Year
NPM # 10: FY 07.

The Injury Prevention Program will be involved in the Nevada Executive Committee on Traffic Safety, which has already been created, and formalized and meets several times a year. This Committee is organized by the Nevada Department of Transportation, and the goal is to address

highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies that are committed to improving highway safety.

The Injury Prevention Program will continue its involvement in the Child Passenger Safety Task Force, which was a result of a recommendation made in the Occupant Protection for Children Assessment, and is organized by the Nevada Office of Traffic Safety Office. The purpose of the Task Force is to provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.

Motor vehicle crashes continue to be a priority of Nevada's Injury Prevention Task Force. The Task Force members will continue to collaborate on motor vehicle crash prevention efforts.

The Injury Prevention Program is and will continue to collaborate with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, the Nevada Department of Public Safety, and the Nevada Office of Traffic Safety.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					22.7
Numerator					
Denominator					
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	25	26	27	29	30

Notes - 2005
This data from CDC is for 2004. The 2005 data will not be available until October 2006.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
NPM # 11: FY 04: 22.7%. Percentage of mothers who breastfeed their infants at six months of age. This data is WIC data.

Data source: Centers for Disease Control Pediatric Nutrition Surveillance System for WIC

In FY05, WIC clinic staff education continued to be a priority for WIC. There were quarterly staff trainings as well as a quarterly newsletter. The WIC Breastfeeding Coordinator was involved with Task Force activities statewide and provided information and assistance to organizations providing lactation services. Also in 2005- Fiscal year 2005, WIC required that all local agencies have a trained Certified Lactation Counselor (CLC) at each clinic to assist participants with breastfeeding problems. The majority of local agencies have exceeded this requirement by training multiple staff members. Local agencies also have designated a staff member to be the Breastfeeding Coordinator for their clinic. This person is responsible for the education and training of other support staff.

The Breastfeeding Peer Counselor program was also initiated this year. State staff attended mandatory USDA training from Loving Support to enable them to train clinic staff and potential peer counselors. In Nevada, 4 local agencies were selected to receive funds for this program

which serve approximately 8,000 participants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Wic Data will continue to be collected for this measure.				X
2. Disseminate statistics to lactation consultants etc. to target activities in identified areas.				X
3. WIC continues to promote breastfeeding and provide breastfeeding education by lactation specialists and breast pumps in clinics statewide.		X		
4. WIC networks with other lactation consultants and healthcare providers statewide to promote breastfeeding.		X		
5. WIC supports the breastfeeding "peer counselor" program				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The WIC Breastfeeding staff attend conferences and workshops, provides information and assistance to local organizations involved in breastfeeding support and remain active in breastfeeding task forces statewide. In addition, she began work on a self-study module for clinic staff which, at its completion by staff members, will ensure a minimum competency level for breastfeeding knowledge within the clinics.

Semiannual trainings are held and select WIC staff from each local agency statewide receive advanced lactation training, earning the designation of CLC. 75% of those counselors are also fluent in Spanish, which addressed the needs of the growing Hispanic population.

WIC purchased 75 hospital grade electric breast pumps to initiate a pump loan program for participants who would otherwise have had to discontinue breastfeeding due to illness or other extended separations.

The Breastfeeding Peer Counselor program continues to operate in 4 local agencies. Additional funding was received from USDA, which may allow for other agencies to implement the program.

State staff and local area breastfeeding contractors attended the United States Breastfeeding Committee Conference in Washington D.C. At this conference staff were able to learn about successful coalition building to enhance and expand breastfeeding promotion throughout the state. The Nevada Breastfeeding Coalition has been established with participants from the Las Vegas and Reno/Carson area.

The Nevada WIC program has entered into a partnership with Cooperative Extension to administer the "Mom's Special Gift Program". This program provides funding for referrals to an International Board Certified Lactation Counselor (IBCLC). WIC participants in the Las Vegas area will be referred for support by the clinic CLC when problems surpass their scope of practice. This will enable WIC to assist women to successfully breastfeed longer.

c. Plan for the Coming Year

2007- Goals:

* Continued participation in the "Mom's Special Gift Program".
* Recruitment of a state breastfeeding coordinator.
* Bi-annual breastfeeding education training to all clinic staff.
* Quarterly newsletter with breastfeeding topics.
* Continued CLC training opportunities.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	35	80	85	94	95
Annual Indicator	34.5	90.8	94.3	92.5	96.2
Numerator	10798	29180	30958	31815	35116
Denominator	31297	32121	32834	34384	36485
Is the Data Provisional or Final?				Provisional	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	97	97	97	97	97

Notes - 2004
The Nevada Newborn Hearing Screening program has been very successful in getting newborn infants screened for hearing deficits. Problems have been encountered in assuring the follow up component. Families who have private insurance (or do not need financial assistance) rarely respond to letters sent offering CSHCN assistance. Attempts to follow up with physicians have been unsuccessful, with HIPAA being sited as the primary reason - along with the lack of time and/or funding to cover the time needed for follow up activities.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
NPM # 12: FY05: Percentage of newborns who have been screened for hearing before hospital discharge. FY 05: 96.5%. (See also State prioity 5, and SPM 5). This data is from state mandated hospital reporting (NRS 442.550), in a Bureau maintained database.

Effective January 1, 2002, the Nevada Legislature mandated newborn hearing screening for all hospitals that provided birthing services for more than 500 births per year.

Newborn Hearing Screening was implemented in Nevada on January 1, 2002 in all hospitals with at least 500 births a year. Staff met with hospitals mandated to provide hearing screening and mutually developed a data collection matrix and reporting protocol. Hospitals reported the number of infants screened, as well as data on infants who needed referral for further evaluation and treatment. Hospitals were provided with information so referrals would be made to the E.I. multidisciplinary clinics to ensure that all babies would be able to access services. Facilities submitted data quarterly relative to the number of infants screened and those who were referred for further evaluation.

The Bureau was awarded a grant for the implementation and expansion of a Newborn Hearing Screening program. This grant allowed the Bureau to hire a full time position to provide follow back services to assure that all babies detected as needing further evaluation and treatment received those services in a timely manner. The individual who was hired to fill the FTE left the positon after six months, thus delaying the follow up acitivies planned. Due to limited funding available in the grant, it was decided to hire a 3/4 time contract employee to fill the position and

"catch - up" follow up activity resumed. As a result, the three month diagnosis timeline, and six month treatment timeline was not always met.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Nevada Newborn Hearing Screening program screens 96.5% of infants born in the State.			X	
2. Familes with infants who were referred for futher hearing evaluation post hospital discharge are contacted by letter and offered assistance.		X		
3. The Newborn Hearing Screening program works with Early Intervention Services to encourage follow up evaluation for hearing and speech and language developmental assessment.		X		X
4. The Newborn Hearing Screening program works with CSHCN to offer families assistance with accessing needed services.	X			
5. The Newborn Hearing Screening program maintains a 'registry" of children who were referred for further hearing evaluation.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities
NPM # 12: FY06.

A full time employee will be hired in the summer of 2006 to continue the hearing screening program activities. The backlog of referrals is now clear and letters were sent to all those families whose infant was referred for further evaluation. The contractor has been meeting with hospital staff and audiologists involved with hearing screenig to identify problem areas in the program. Providers have continued to provide data on a monthly basis, and the data is then put into a SHD database to track cases. Only hospitals delivering more than 500 babies per year are required to provide hearing screening for newborns prior to discharge.

Infants who "fail" the initial Newborn Hearing Screening are referred to their PCP and to the E.I. clinics for further evaluation. Families needing financial assistance are referred into the CSHCN program, which can cover the costs associated with surgery and/or hearing aides if needed. The infants continue to be seen and evaluated by E.I. staff to assure that the child meets appropriate developmental milestones. E.I. services transition the children into the school district special education program at 3 years of age, thus avoiding any break in service and assuring that the child achieves its maximum potential. This provided a "seamless" system of assistance to families.
The Health Division was awarded a continuation grant to expand the Newborn Hearing Screening Program and its capacity to collect enhanced follow up information from families, physicians and audiologists.
Problems still exist with gathering timely follow up data on infants referred for further evaluation. Families are not responding to the follow up letters, nor to a second follow up letter. E.I. clinics and staff are collaborating regarding case outcome information and doing increased cross referral. Private providers are refusing to provide any follow up data due to HIPAA concerns and are reluctant to commit to spending the time referring patients to the NBHS program. Staff

secured an Attorney General opinion that states there is no HIPAA violation when reporting data on a state mandated program. Hopefully, this will improve our ability to collect follow up data. However, the contractor resigned after approximately six months, thus slowing the progress on these goals. The HD is in the process of hiring an FTE to fill this position and proceed with the plans in place.

Newborn Hearing program staff continue to meet the Real Choice Systems Change grant staff to share the results of the Newborn Hearing Screening needs assessment. Many of the issues identified are being addressed in the RCSC pilot projects and the RCSC grant is evaluating ways to improve the statewide infrastructure for the hearing impaired. Linkages with community groups involved with the hearing impaired were established to exchange ideas and identify funding sources to develop improved resources statewide.

c. Plan for the Coming Year

c. Plan for the Coming Year
NPM # 12: FY07.

Plans are to continue to work with hospitals to enhance the quality and timeliness of data. Follow-back services will be enhanced to assure that all infants screened received appropriate follow-up treatment if indicated. Staff plan to contact all specialty ENT physicians and audiologists in the state and will advise them of the legal opinion from the Attorney General's office that clarifies HIPAA requirements and allows reporting of information for screening programs. Staff will continue to work with hospital staff and individual providers to enhance data quality and timeliness, as well as develop standardized protocols and procedures for referral. Plans are to link with Medicaid and Nevada Check Up data to improve the capacity to assure effective treatment in a timely fashion.

Legislation in place mandates an annual report to the Governor. However, as the program continues and improves, not only data collection/reporting will improve, but additional analysis will be provided on follow-up, enrollment in E.I. etc. This data will be available for use by the Nevada Advisory Council on CSHCN to utilize in making recommendations for improvements in services to CSHCN. Plans are to meet with hospital staff to work on improvements in data collection and analysis that will produce not only improved information for state agencies, but also for individual hospitals.

The bill that established an Office of Disabilities in the DHR Director's Office also established a committee on Deaf and Hard of Hearing. The RCSC team and the Nevada Advisory Council on CSHCN will work with this committee. The RCSC team will link the Office of Disabilities - Deaf and Hard of Hearing committee with the Nevada Advisory Council on CSHCN relative to sharing data from the hearing needs assessment, transition issues and recommendations made as a result of the RCSC needs assessment.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	20	19	19	18	18
Annual Indicator	21.4	19.1	19.1	17.7	18.6
Numerator	117118	112259	110568	105473	

Denominator	546068	587695	578890	595895	
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	17	17	16	14	14

Notes - 2005
this is an estimated measure

Notes - 2004
See explanation in NPM 13.a.

a. Last Year's Accomplishments
NPM 13: FY 05: 18.6% The most current reliable estimate (February 2005) of the percent of Nevada children ages 0-18 without health insurance was 18.6% in 2004. The estimate, which is utilized by the Health Division, is based on a study entitled "Uninsured Persons in Nevada" conducted by Decision Analytics in 2004 for Great Basin Primary Care Association (GBPCA). There has not been a more recent, definitive study for Nevada or for Nevada's children, in particular, since then. The 18.6 percentage figure is a .5% decrease from the FY 03 figure of 19.1%. The estimated number of children from birth to age eighteen without health insurance was 125,856 in 2004. The number of children birth to eighteen used in the study was 677,189. Efforts to improve this measure are related to Infrastructure Services in terms of the Performance Measurement System. (See State Priority 1, and SPM 7)

It is generally agreed that the most important reason for a decrease in the percent of children without health insurance was the significant increase in enrollment in Nevada Check Up. Nevada Check Up is the State Children's Health Insurance Program for children 0-18. Over half of uninsured Nevadans are working families and less than one-third of uninsured children in our state live below the federal poverty level. The Nevada Check Up program covers up to 200% of the federal poverty level. Nevada Check Up dramatically increased enrollment during the past three years to over 28,000 children. The Bureau worked closely with Nevada Check Up. A report on it is a standing agenda item for the Maternal and Child Health Advisory Board.

Major activities related to the decrease included improvement of the primary care safety net to promote access to care and public and private programs targeted to children. BFHS carried out a range of free public health programs and services which contributed to improving this performance measure by compensating for the lack of health insurance suffered by such a large number of children in the state. The Primary Care Development Center (PCDC) represents the Bureau's main effort related to improvement of the primary care safety net to promote access to primary care. The primary care safety net is another means for mitigating the limitations to care related to lack of medical insurance for children. Other Bureau programs that promoted access to care included the MCH Campaign Information and Referral Line, which refers callers to Medicaid and Nevada Check up as well as other programs that might serve and refer them such as WIC and CSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support expansion of Nevada Check Up to increase enrollment.		X		
2. Facilitate the improvement of the primary care safety net to promote access to care by designing and recommending primary care, dental, and mental health HPSAs, MUPs, and MUAs.				X
3. Continue to promote referrals to and from public and private		X		

programs targeted to children, i.e. Early Intervention, WIC, the MCH Campaign, and members of GBPCA.				
4. Update the Nevada Uninsured Study every two years to assess needs.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Because of the gradual increase in enrollment in Nevada Check Up, it is generally agreed that the percentage of uninsured children has stabilized or decreased slightly. Nevada's percent of total uninsured persons remains consistently higher than the national average. National research and Nevada studies clearly demonstrate that uninsured children do not get the health care they need. This is particularly true for rural residents who are more to be uninsured and less likely to be offered coverage through employers. Uninsured children have fewer physician visits per year, are less likely to receive adequate preventive services and immunizations, and are less likely to be seen by physicians when they are ill.

In FY 06 as in the preceding year, the Bureau carried out a range of free public health programs and services that offset the obstacles hindering access to care caused by lack of medical insurance. Uninsured children would be very unlikely to receive these kinds of services and benefits otherwise. The MCH Campaign is designed to reduce infant mortality and morbidity by establishing statewide systems of perinatal care to ensure that pregnant women have access to prenatal care regardless of ability to pay. The Bureau's Child and Adolescent Health program promotes healthy behaviors among Nevada's youth through organized community efforts, public awareness campaigns, educational programs, and prevention activities. The CSHCN program provides a range of services that are coordinated, family-centered, community-based, and culturally competent. The Oral Health program provides preventive and health education services to children throughout the state. The purpose of the Women, Infants, and Children (WIC) program is to improve the nutritional health status of low-income women, infants, and children through nutrition education, vouchers for supplemental foods, and referral to community resources. Real Choice Systems Change seeks to enhance linkages and improve coordination of services. This year it partnered with Covering Kids to promote Nevada Check Up in its media campaign. PCDC continued to represent the Bureau's main effort related to improvement of the primary care safety net to promote access to primary care. The primary care safety net is another means for mitigating the limitations to care related to lack of medical insurance for children.

c. Plan for the Coming Year

In the future, the Bureau will continue to carry out its ongoing activities outlined above, all of which serve to ameliorate the impact of lack of health insurance on Nevada's children. The Bureau will also continue to work closely with Nevada Check Up, which is expected to continue to increase enrollment. The Bureau, mainly through PCDC, will continue its work related to improvement of the primary care safety net to promote access to care. These efforts are targeted to the medically underserved, most of who are uninsured or underinsured. The medically underserved are spread throughout Nevada's vast rural areas and in pockets of poverty in Nevada's two urban centers of Reno and Las Vegas. Two factors which have a special impact on Nevada's uninsured and may negatively affect Nevada's rates are that the Hispanic population continues to rise dramatically and Hispanics are twice as likely to be uninsured and that fewer persons than the national average participate in Medicaid programs.

PCDC will also continue to support community development activities related to improvement of primary care resources available to medically underserved populations which, in turn, serves to offset the impact of lack of health insurance among children. Key partners for PCDC include Great Basin Primary Care Association, University of Nevada School of Medicine, Nevada Health Centers, Nevada Rural Hospital Partners, and the Office of Rural Health. These activities represent the leading efforts related to this measure and will continue to be the leading efforts next year.

The MCH Campaign Information and Referral Line will continue to be a resource for referral to pediatric care as well as to Medicaid and Nevada Check Up.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					15.8
Numerator					
Denominator					
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	15	14.5	14	14	13.5

Notes - 2005
This data from CDC analysis of WIC data is from 2004. 2005 data will not be available until October 2006.

a. Last Year's Accomplishments
The prevalence of overweight WIC children in Nevada ages 2-5 years is 15.8%, which is slightly higher than the national average of 15.7%. The rate of obese children is lower at 14.3%, which is also lower that the national average of 14.7%. (See State Priority 8).

In FY 2005 all WIC clinic staff was given training on the "New Food Guide Pyramid". The Nevada WIC program contracted with the University of Nevada Reno to develop a comprehensive training on facilitated learning and goal setting. A 3 day conference was provided to all WIC staff around this topic.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC will continue PedNSS to monitor the percent of children at or above the 85th percentile				X
2. State staff will receive training on VENA (Value Enhanced Nutrition Assessment) to train local agency staff on better education methods.		X		
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities
State staff will receive training from USDA on VENA (Value Enhanced Nutrition Assessment) to train local agency staff on better education methods. Local agency staff will also be attending a workshop in August to learn about new methods in educating parents of overweight children.

c. Plan for the Coming Year
Goals:
* Implementation of VENA guidelines.
* Development of training modules to ensure staff competencies.
* Coordinate with 5-A-Day Coordinator to provide educational and training materials.
* Coordination with the Obesity Coalition.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					7.6
Numerator					2771
Denominator					36479
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	7	7	6	6	5

Notes - 2005
This data comes from the Bureau of Health Planning and Statistics, CHDR. Data for women who smoked in the last three months of pregnancy is unavailable. Data consists of women who smoked at any time during their pregnancy (numerator) and the number of women who gave birth (denominator).

a. Last Year's Accomplishments
NPM #15 FY 05 7.6%

Percentage of women who smoke in the last three months of pregnancy.
This performance measure is new. Data comes from Bureau of Health Planning and Statistics. Data for the number and percent of women who smoked in their last three months of pregnancy is unavailable. Available data consists of the number of women who smoked anytime during their pregnancy. Past activities include contracting with obstetrical health care providers (the MCH Campaign) to serve high-risk, low-income women. All women seen through these providers are screened for perinatal substance abuse, including tobacco. Clients are referred to a variety of agencies and a help-line that will encourage them in their efforts to quit smoking.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with obstetrical providers to serve high-risk, low-income women and screen for drug abuse, including tobacco use.		X		
2. Partner with other public and private agencies to conduct public education regarding pregnancy and smoking.			X	
3. Refer women who are seen in MCH Prenatal program and those who call in to the MCH Information and Referral line to the Tobacco Users Help Line.		X		
4. Seek additional funding to conduct a statewide media campaign on pregnancy and smoking.			X	
5. Support efforts to curb smoking in public places.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
NPM #15b FY 06

Current activities include the Perinatal Substance Abuse Prevention program collaborating with other public and private agencies to increase awareness of the dangers of smoking during pregnancy. The Health Division also has a Tobacco Control Program, which recently published a strategic plan. There is also information on the Health Division website about pregnancy and smoking. The Health Division is working with others to have a "Clean Indoor Air Act" on the November 2006 ballot as an initiative. Work also is being done to enact stronger tobacco control laws. The Bureau collaborates with the Nevada Tobacco Users Helpline, referring pregnant women who smoke to this resource. Health care providers in the MCH Campaign are also encouraged to screen all their patients for tobacco use, and refer as necessary. Obstetrical centers that have contracts with the Bureau to care for pregnant women screen all clients for tobacco and illicit drug use.

c. Plan for the Coming Year
NPM #15c FY 07

Future activities include the Perinatal Substance Abuse Prevention program continuing collaborating with other public and private agencies to increase awareness of the dangers of smoking during pregnancy. The Health Division's Tobacco Control Program will continue to follow their strategic plan. All contracted obstetrical centers will continue to screen for tobacco use among pregnant and postpartum women, referring those who smoke to various quit-smoking support programs. Collaboration with the Maternal and Child Health Coalitions and the Tobacco Users Help Line will also be increased in the next year.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005

Annual Performance Objective	9	8	7	6	14
Annual Indicator	6.6	6.6	13.2	11.5	6.7
Numerator	9	10	21	19	12
Denominator	135560	150965	159580	165297	177850
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	7	7	6	6	5

a. Last Year's Accomplishments
Data reported for this performance measure comes from the CHDR, death certificates. This is preliminary data. This measure is an infrastructure building measure and affects children from age fifteen through nineteen. (See State Priority 3, and SPM 8).

The 2005 Youth Risk Behavior Survey (YRBS) reported 16% of Nevada's high school students have seriously considered suicide during the past 12 months. Fifteen percent planned how they would commit suicide and 9% actually attempted suicide.

The Governor's Youth Advisory Council has again selected suicide prevention as one of their top priorities. They are currently reorganizing the Council and will soon start to focus on their priorities.

The Child and Adolescent Program worked with the new state Suicide Prevention Coordinator to ensure youth issues were addressed.

The Injury Prevention Program applied and received a non-competing supplemental grant through the Centers for Disease Control and Prevention (CDC) for Violence Surveillance Integration. This funding will require Nevada to integrate Violence Surveillance into the current Core State Injury Surveillance System. Violence Surveillance includes suicide mortality data and hospitalization for self-inflicted injuries data for the state. This data will be reported to the CDC. At that time the Injury Biostatistician was a contracted employee.

PCDC continued to work with GBPCA to promote sites where mental health services for adolescents can be obtained.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Injury Prevention Program performs data surveillance on suicides throughout the state of Nevada.				X
2. The Injury Prevention Program is and will continue to collaborate with the Crisis Call Center of Northern Nevada.			X	
3. The Injury Prevention Program is and will continue to collaborate with the Nevada Office of Suicide Prevention.			X	
4. The PCDC will continue to designate Mental Health HPSAs, MUPS and MUAS.				X
5. The Child and Adolescent Health program will continue collaborating with other state agencies on issues that effect suicide prevention.			X	
6. The Governor's Youth Advisory Council continues to identify suicide prevention as a priority issue and will address it in 2007.			X	
7. The Child and Adolescent Health program will continue collaborating with the state Suicide specialist to ensure youth issues are addressed.			X	

8.				
9.				
10.				

b. Current Activities
The Governor's Youth Advisory Council has again selected suicide prevention as one of their top priorities. They are currently reorganizing the Council and will soon start to focus on their priorities.

The Injury Prevention Program collaborates with the newly formed Nevada Office of Suicide Prevention. The Injury Prevention Coordinator attended Community Core Competencies Training on Suicide Prevention that the Office of Suicide Prevention sponsored. In addition the Office of Suicide Prevention has been added as a member agency on the Injury Prevention Task Force. The Child and Adolescent Program works with the Nevada Office of Suicide Prevention to ensure youth issues are addressed.

The Injury Biostatistician collects and analyzes suicide data for the state of Nevada. In this year this position became an FTE. The state received a five year injury prevention grant from CDC to continue its injury prevention activities.

In Addition, the Child and Adolescent Health program is working with the Division of Child and Family Services on a State Infrastructure Grant aimed towards improving mental health services for Nevada's children and youth. They are also participating on the Bureau of Alcohol and Drug Abuses State Epidemiology Workgroup which has been developing outcome measures for substance abuse prevention including outcomes for dual diagnosed children and youth. These efforts also focus on suicide prevention from the standpoint of both treatment and prevention.

PCDC continues to work with GBPCA to promote sites where mental health services for adolescents can be obtained.

c. Plan for the Coming Year
The Data Surveillance of Suicides in Nevada will continue through 2007.

The Injury Prevention Program and Child and Adolescent Programs will continue to collaborate with the Nevada Office of Suicide Prevention.

The Injury Biostatistician will continue to collect and analyze suicide data for the state of Nevada.

PCDC will continue to work with GBPCA to promote sites where mental health services for adolescents can be obtained.

The Child and Adolescent Health program will continue collaborating with the Division of Child and Family services and the Bureau of Alcohol and Drug Abuse to help improve both treatment and prevention programs for children and youth.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	95	95	95	95	95
Annual Indicator	90.9	88.1	89.8	86.6	88.6
Numerator	298	362	388	382	411
Denominator	328	411	432	441	464
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	95	95	95	95	95

a. Last Year's Accomplishments
NPM # 17: FY 05: 88.6%

The percent of very low birth weight infants delivered at high-risk (level III) facilities. The data for this measure has come from State vital statistics, CHDR. This measure is an infrastructure building measure that impacts all low birthweight infants born in Nevada. Infants should be delivered at facilities that have appropriate care to match their needs.
The Maternal and Child Health Campaign has aired announcements on television and radio about the importance of entering early and continuous prenatal care. Proper nutrition and refraining from alcohol, tobacco and drugs has also been stressed to decrease the incidence of low-birth weight babies. The MCH information and referral line is also available to all women and families seeking information about a variety of topics, including where to obtain appropriate prenatal care. In addition, the agency contracted to provide obstetrical services to low-income, high-risk pregnant women is required to refer high-risk pregnant women to appropriate services, both medical and social. This will include referring women to physicians who deliver high-risk mothers at a facility with a Level III nursery.
A "Request for Proposal" was released and two agencies that provide obstetrical care were selected. One vendor was in Southern Nevada area and one in Northern Nevada. One of the factors that was considered when selecting the vendors was the availability of appropriate care for the newborn.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Perform outreach and enroll qualified pregnant women into WIC, where they will receive referrals to needed services.		X		
2. Review and revise, if needed, NAC's re NICUs to ensure up-to-date requirements.		X		
3. Provide obstetrical coverage for women through community based providers.		X		
4. Collaborate with MCHAB to educate public and providers about risks of having low birth weight baby.		X		
5. Promote early entry into prenatal care for all women in NV through the Maternal and Child Health Campaign.			X	
6. Continue to monitor the percent of low birth weight infants delivered at facilities for high risk neonates to evaluate efforts and plan future initiatives.				X
7.				
8.				

9.				
10.				

b. Current Activities
NPM # 17: FY 06:

The Maternal and Child Health Campaign has continued to conduct a mass-media, public education campaign about the importance of entering early and continuous prenatal care in order to reduce the low birth weight rate and infant death rate. The MCH information and referral line (1-800-429-2669) is available to all women and families who may need information regarding neonatal care. In addition, the contracted community based obstetrical providers in both the north and south of the state, are required to refer high-risk pregnant women to appropriate services, both medical and social. This includes referring women to physicians who deliver high-risk mothers at a facility with a Level III nursery.

c. Plan for the Coming Year
NPM # 17c: FY 07:

The Maternal and Child Health Campaign will continue to conduct a mass-media, public education campaign about the importance of entering early and continuous prenatal care in order to reduce the low birth weight rate and infant death rate. The MCH information and referral line (1-800-429-2669) is available to all women and families who may need information regarding neonatal care. In addition, the contracted community based obstetrical providers, located in both southern and northern Nevada, are required to refer high-risk pregnant women to appropriate services, both medical and social. This includes referring women to physicians who deliver high-risk mothers at a facility with a Level III nursery. The Bureau will ask the 2007 legislature for additional funding for the MCH Campaign. If granted, the funding will be used to contract with additional providers. All providers will be required to refer high-risk mothers to physicians who deliver at facilities with a Level III nursery.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	80	75	76	77	80
Annual Indicator	75.6	74.6	75.5	74.4	67.3
Numerator	23645	24468	25362	26157	24542
Denominator	31297	32798	33605	35147	36479
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	74	76	78	80	85

a. Last Year's Accomplishments
NPM # 18a: FY 05: 67.3%
The percent of infants born to women who began prenatal care in their first trimester. Data for this infrastructure building performance measure has come from State Vital Statistics, CHDR, and affects all newborns within the state. It is desired that all infants in Nevada be born to pregnant women receiving prenatal care beginning in the first trimester and continuing throughout the pregnancy.
The Maternal and Child Health campaign funded one obstetrical provider in Southern Nevada to

provide services to low-income, high-risk pregnant women. This provider served 600 women during the year. Through the contract, the provider attended health fairs and other functions to encourage women to seek early (first trimester) prenatal care. All of their services were available in English and Spanish.
The Bureau also contracted with the Economic Opportunity Board of Clark County to provide obstetrical services to low income women, thus helping women who cannot afford prenatal care, and may not qualify for Medicaid, to obtain early and continuous prenatal care. The Washoe County District Health Department also received Bureau assistance to provide care to high-risk women in Washoe County.

In addition, the Bureau contracted with the Nevada Broadcasters' Association to conduct a statewide radio and television campaign that encouraged pregnant women to obtain early and continuous prenatal care. All of the announcements were in English and Spanish. This campaign was made possible through a contract with Medicaid, which matches 1:1 money spent on public education.

The Maternal and Child Health Line staff provided callers with information on where they could obtain prenatal care, and attended health fairs regularly throughout the state. The information and referral line was staffed by a bilingual (English and Spanish) person.

The Bureau released a "request for proposal" asking for proposals from obstetrical providers willing to serve low-income, high-risk pregnant women. Two vendors were selected for FY06 -- FY09. Contracts with these vendors ensured that pregnant women gained early entrance into prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Sponsor a public education campaign regarding the need for early prenatal care.			X	
2. Distribute brochures and other printed materials at clinics, health fairs on early prenatal care.			X	
3. Collaborate with providers to offer prenatal care to pregnant women regardless of their ability to pay.		X		
4. Provide prenatal care to low-income pregnant women through contracted agencies.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
NPM #18b: FY 06:

The Bureau is continuing the Maternal and Child Health Campaign, including contracting with two obstetrical centers to provide full obstetrical services to low-income, high-risk pregnant women who are not eligible for Medicaid or Nevada Check-Up. One vendor is from Southern Nevada and the other vendor is from Northern Nevada.
The Bureau has been conducting an educational campaign to make women aware of the need for early and continuous prenatal care. This is a poster and bus billboard campaign in English and Spanish. In addition, brochures have been produced and are being disseminated throughout

southern Nevada. The educational campaign is a result of collaboration with Medicaid. Medicaid matches all educational funding 1:1. To complement the educational campaign, the Bureau maintains a toll-free, statewide health line where women and families can access information regarding a variety of information, including where to obtain prenatal care and social/mental health services.

c. Plan for the Coming Year
NPM #18c: FY 07:

The Bureau will continue contracting with the two obstetrical centers as part of the Maternal and Child Health (MCH) Campaign, to provide full obstetrical services to low-income, high-risk pregnant women who are not eligible for Medicaid or Nevada Check-Up. One vendor is from Southern Nevada and the other vendor is from Northern Nevada.
The Bureau will continue conducting an educational campaign to make women aware of the need for early and continuous prenatal care. This is a poster and bus billboard campaign in English and Spanish. In addition, brochures will continue to be produced and disseminated throughout southern Nevada. Collaboration with Medicaid will also continue. Medicaid matches all educational funding 1:1. To complement the educational campaign, the Bureau will maintain a toll-free, statewide health line where women and families can access information regarding a variety of information, including where to obtain prenatal care and social/mental health services. The Bureau has received permission from the Director and the Governor to ask the 2007 legislature for additional funding for the MCH Campaign. If received, the funding will be used to contract with additional providers who work with the African American community and within a rural community.

D. State Performance Measures

State Performance Measure 1: *The percent of women of child-bearing age who receive screening and assistance for domestic violence should be increased.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	22	15	18	10	10
Annual Indicator	7.9	8.1	7.4	7.7	7.2
Numerator	34727	38003	35814	38229	38107
Denominator	442030	468635	484433	497955	528027
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	10	15	15	15	15

a. Last Year's Accomplishments
SPM #1: FY 05: 8.4%. The percent of women of childbearing age who receive screening and assistance for domestic violence should be increased. (See State Priority 7)

This data comes from the Nevada Network Against Domestic Violence and clinics the Bureau contracts with to provide obstetrical care for the numerator, and the denominator is from the State Vital Statistics, CHDR, using census data and data from the state demographer. All clinics contracted to provide MCH services through the Maternal/Child Health Campaign must provide domestic violence screening. This population based state performance measure is used to measure how many women have been screened and assisted for domestic violence. Increased

assistance from the community and health care providers to women subject to intimate partner violence is needed in order to help all the women who are victims of this violence.
Activities involved performing a statewide needs assessment to determine what the judicial, law-enforcement and advocate/shelter systems needed to continue domestic violence prevention.
The Bureau contracted with several agencies to provide prenatal and full obstetrical services to low-income, high-risk pregnant women. All women were screened for domestic violence and referred to a variety of social service agencies if indicated.
The Bureau collaborated with the Nevada Network Against Domestic Violence to continue the "health care standards" work. Avenues were explored to determine the best way to advance domestic violence screening into the medical and nursing schools throughout the state.
Bureau staff have presented information on domestic violence at conferences throughout the state.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue promoting the statewide domestic violence health screening protocols.			X	
2. Collaborate with the Nevada Network Against Domestic Violence in conducting on-going training classes to health care providers.		X		
3. Collaborate with the medical and nursing schools to adopt and teach their students the statewide screening protocols.			X	
4. Collaborate with a variety of agencies to educate the public about domestic violence.			X	
5. MCH serves on the Nevada Attorney General's Domestic Violence Prevention Council.		X		
6. Select health care related objectives from the completed Needs Assessment and begin fulfilling those objectives.				X
7.				
8.				
9.				
10.				

b. Current Activities

SPM # 1b: FY 06:
The Domestic Violence Needs Assessment was completed and Bureau staff, in addition to the Attorney General's Domestic Violence Prevention Council, is in the process of assessing what priorities will be worked on from all the issues that were identified in the Needs Assessment.
Bureau staff continues to collaborate with the Nevada Network Against Domestic Violence on presenting domestic violence screening tools to nursing and medical schools. It is being emphasized that these tools should be incorporated into the existing nursing/medical school curriculum.
The Bureau has the statewide, toll-free Maternal and Child Health (MCH) Line available for callers needing referral to a social service agency in their area. In addition, staff attend health fairs and conferences throughout the state to educate women and families about the availability of the line, and the services offered. The MCH Campaign includes contracting with obstetrical clinics to see low income, high-risk pregnant women. All clinics screen for domestic violence.

c. Plan for the Coming Year

SPM # 1c: FY 07:
Once the priorities from the Domestic Violence Needs Assessment are selected, the Bureau will begin working on those related to the health care field. In addition, staff will continue to collaborate with the Attorney General's Council for the Prevention of Domestic Violence (formerly known as the Domestic Violence Prevention Council). Bureau staff will continue to partner with the Nevada Network Against Domestic Violence on the Health Care Standards team to have domestic violence screening become standard throughout the state. In addition, the Bureau will continue the statewide, toll-free Maternal and Child Health Line for callers needing referral to a social service agency in their area. The Bureau will also continue the MCH Campaign, and has permission from the Director and the Governor to ask the 2007 legislature for additional funding. This funding will be used to expand the MCH Campaign, specifically targeting African Americans and a rural community. If the funding is received, any additional services will continue to include domestic violence screening.

State Performance Measure 2: *The rate of significant Medicaid dental providers to the Medicaid population of children, youth and women of childbearing age (15-44) should be increased.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					1.8
Numerator					298
Denominator					167271
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	1.9	2	2.1	2.2	2.3

Notes - 2005

a. Last Year's Accomplishments
SPM 2: FY 05. The rate of significant Medicaid dental providers to the Medicaid population of children, youth and women of childbearing age should be increased. The ratio of providers to population. SFY: 05 1.84 per 1,000. (See State Priority 2).

For FY 05, the rate was 1.84. The numerator is the number of dental providers paid >$1,000 by Medicaid (298). The denominator is the number of children, youth and women of childbearing age (15-44) in the Medicaid population (167,271). Reporting of this measure comes from the Division of Health Care Financing and Policy.

Historically, the ratio of dentists to population in Nevada has been one of the lowest in all 50 states. Legislation enacted in FY 2001, allowing for licensure by credential and in FY 2005, providing for participation in a regional dental examination board has resulted in a significant increase in the number of Nevada licensed dentists.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to collect, analyze and report data on the MCH				X

population covered by Medicaid.				
2. Continue to provide technical support to the Medicaid Dental Clinical Review Advisory Committee. Continue to provide technical support to the Medicaid Dental Clinical Review Advisory Committee.			X	
3. Continue to provide support to the six regional oral health coalitions in Nevada.			X	
4. Continue to support recruitment of dental providers to serve underserved populations through participation on the WICHE Advisory Board and the establishment of Dental Health Professional Shortage areas by the PCDC.		X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
SPM 2: FY 06. Access to preventive oral health services for the Medicaid population of children, youth and women of childbearing age should be increased.

In order to improve access to dental services for the Medicaid MCH population, participation in the Medicaid program by Nevada licensed dentists needs to improve. In FY 06, the two HMOs in urban southern Nevada opened up their provider panels resulting in a significant increase in the number of providers who accept Medicaid in Clark County. In addition, the Division of Health Care Financing and Policy re convened the Medicaid Advisory Committee (MAC) Dental Clinical Review Advisory Subcommittee (CRAS). Members of the subcommittee are working closely with the Division of Health Care Financing and Policy to address issues that inhibit participation by dental providers in Medicaid.

The PCDC continues to identify Dental Health Professional Shortage Areas to promote dental services in Federally Qualified Health Centers and Tribal Health Centers, which will accept Medicaid patients.

c. Plan for the Coming Year
SPM 2: FY 07. Access to preventive oral health services for the Medicaid population of children, youth and women of childbearing age should be increased.

In FY 07, Nevada Medicaid will initiate a dental HMO in urban northern Nevada. The Division of Health Care Financing and Policy hopes that doing so will increase the number of dental providers in northern Nevada as it did in southern Nevada. In addition, it is anticipated that a number of organizations will advocate during the 2007 Nevada Legislative session for funding and policy changes that would result in increased access to dental services for the Nevada MCH population that is covered by Medicaid.

The PCDC will continue to identify Dental Health Professional Shortage Areas to promote dental services in Federally Qualified Health Centers and Tribal Health Centers, which will accept Medicaid patients.

State Performance Measure 3: *The percent of obese women ages 18 to 44 should be decreased.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					19.7
Numerator					104021
Denominator					528027
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	18	18	17	17	16

a. Last Year's Accomplishments
Nevada Health Division had no formal activities with respect to this objective in FY 2005. (See State Priority 8).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with existing local obesity coalitions to identify current referral resources and key local clinical organizations willing to establish behavioral-based weight management programs.				X
2. Provide program information and support to identified organizations to become licensed providers of behavioral-based weight management programs.				X
3. Utilizing public health marketing strategy, educate existing partners on current behavioral-based weight management programs and encourage partners to refer obese NV women 18-44 and their families to existing programs and newly formed programs.		X		
4. Promote and support the adoption of the "5 A Day" fruit and vegetable campaign into NV communities.				X
5. Work with state-level NDOT personnel to create safe routes for pedestrian and bicyclists to facilitate daily increased physical activity in communities throughout NV.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Realizing the importance of decreasing the obesity rate within this population, NVHD has been communicating with partners and developing a community-based plan to implement in FY 2007.

c. Plan for the Coming Year
NVHD will encourage the establishment of behavioral-based weight management programs throughout the state, and use existing MCH programs as a referral base. The strategic plan includes:
Work with existing local obesity coalitions to identify current referral resources and key local clinical organizations willing to establish behavioral-based weight management programs, over 10

weeks in duration, (especially Lifesteps and Shapedown).

Provide program information and support to identified organizations to become licensed providers of behavioral-based weight management programs.
Utilizing public health marketing strategy, educate existing partners (WIC, Head Start, School Nurses, Medicaid, Cooperative Extension, Family Resource Centers, county health districts, contract Registered Dietitians, and the media among others), on current behavioral-based weight management programs in their local areas and encourage partners to refer obese NV women 18-44 and their families to existing programs and newly formed programs.

Promote and support the adoption of the "5 A Day" fruit and vegetable campaign into NV communities. Targeted places include supermarkets, restaurants, day care centers, hospitals and school districts.
Work with state-level NDOT personnel to begin dialogue for the need to create safe routes for pedestrian and bicyclists to facilitate daily increased physical activity in communities throughout NV.

State Performance Measure 4: *Teen birth rate (per 1,000) among Hispanic adolescents ages 15-17 should be reduced.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					48.2
Numerator					754
Denominator					15649
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	30	30	30	30	30

a. Last Year's Accomplishments
SPM # 4. The rate of birth (per 1,000) for Hispanic teenagers aged 15 through 17 years should be reduced. FY05: 48.7 per 1,000 (preliminary). Data for this measure is from State Vital Statistics, CHDR, birth certificates.

The main activities for Nevada's teen pregnancy prevention initiative included community involvement through community organizations, the Nevada Statewide Coalition Partnership, which is a network of prevention coalitions located in ten of Nevada's seventeen counties, and the continuation of the Governor's Youth Advisory Council, which has identified teen pregnancy prevention as one of its top three priorities.

The majority of Nevada's abstinence education funds were made available to the community organizations through subgrants via an RFP process. These funds were targeted towards the Hispanic/Latino populations of Clark and Washoe counties which are the state's most populous counties with the highest rates of teen births.

Some funds were also used to promote parental communication and connectedness throughout the State. Two subgrants provided education for parents in the various issues of teen maturation and how to talk to their children about abstinence. Positive Choices, Positive Futures was a popular program in Clark County as the Area Health Education Center of Southern Nevada continued to be successful in marketing it especially with the Hispanic/Latino community. PCPF is available and often taught in Spanish. An attempt to replicate the program in Northern Nevada was explored.

Materials in the Teen Pregnancy Prevention Resource Center were made available to community organizations and other interested parties upon request. The State Health Division maintained the State Teen Pregnancy Prevention website: http://health2k.state.nv.us/CAH/teenpregprevention.htm, which offers resources to the public.

Bureau staff continued to seek other opportunities to work collaboratively with various communities within communities that can include racial/ethnic groups, migrant families, youth with special health care needs, youth in foster care, and run away and homeless youth. An initiative to combine efforts to prevent STDs, HIV and teen pregnancy by addressing common risk factors as well as promoting protective factors continued. This initiative is was collaboration between the State Department of Education, the State Division of Mental Health and Developmental Services, the State Division of Child and Family Services, the State Welfare Division, and the State Health Division's Bureau of Family Health Services, Bureau of Community Health, and Bureau of Alcohol and Drug Abuse. The name of the collective group was the Nevada Stakeholders for the Reduction of Adolescent Risk Behaviors.

The abstinence education media campaign with Nevada Broadcasters Association began again in late FY 05.

The Governor's Youth Advisory Council (GYAC) continued their "Abstinence Works!" presentations on a limited basis.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Governor's Youth Advisory Council's continued commitment to teen pregnancy prevention via keeping TPP as one of their top priorities.			X	
2. Support of community coalitions and organizations (including ones emphasizing minority populations) by making federal abstinence education funds available for subgrants for abstinence education and developing partnerships with the GYAC.		X		
3. Continuation of a statewide media campaign with Nevada Broadcasters Association promoting sexual abstinence, including Spanish language spots.			X	
4. Continue supporting workshops for parents of adolescents with an emphasis on the Hispanic/Latino community, teaching them the importance of healthy sexuality.		X		
5. Development and implementation of teen pregnancy prevention programs specifically targeting the Hispanic/Latino populations in Washoe and Clark Counties.			X	X
6. Continue maintenance of TPP webpage and resource center.			X	
7. Continue supporting teen health clinics in Washoe and Clark Counties.		X		
8. Continue supporting local school districts throughout Nevada, especially Clark County which is the fifth largest school district in the Nation.		X		
9.				
10.				

b. Current Activities

Bureau staff continues to seek other opportunities to work collaboratively with various communities within communities that can include racial/ethnic groups, migrant families, youth with special health care needs, youth in foster care, and run away and homeless youth. The media campaign with Nevada Broadcasters Association continues in 2006. Six new radio non-commercial sustaining announcements (NCSA) were created in English and are being translated into Spanish. Once completed the Spanish NCSAs will air throughout Nevada until the subgrant ends September 30, 2007.

Bureau staff and the MCH Advisory Board continue to work with the Clark County School District, the fifth largest school district in the United States, to improve their sex education curriculum. The Bureau, through the Abstinence Grant, provides updated educational media and materials to the school district, and has expanded to include materials for three additional school districts.

c. Plan for the Coming Year

The media campaign with Nevada Broadcasters Association will continue in FFY 07. Six radio non-commercial sustaining announcements (NCSA) were created in English and were translated into Spanish. Both the English and Spanish NCSAs will continue to air throughout Nevada until the subgrant ends September 30, 2007.

The Bureau, through the Abstinence Grant, will continue to provide updated educational media and materials to the 17 school districts throughout the State.

Bureau staff has requested a budget enhancement for teen pregnancy prevention for the Health Division. The Bureau is asking for $400,000 to build capacity for primary and secondary prevention of teen births. The primary prevention portion of this budget enhancement would serve to send out a request for proposal (RFP) to the general population of Nevada. The resultant contract would establish a program in a community for teen pregnancy prevention utilizing an evidenced based positive youth development program, such as Straight Talk or Parenting Wisely. The secondary prevention portion of the budget enhancement would establish an Education Coordinator position within the Bureau of Community Health, who would coordinate with school and community health (urban and rural) nurses. In addition, funding for two existing teen health clinics would be increased, and an RFP for funding for a rural clinic would be run.

State Performance Measure 5: *Increase the percent of infants born in the state who have a newborn hearing screening prior to discharge from the hospital.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator			94.4	96.4	96.2
Numerator			29180	31815	35116
Denominator			30924	33000	36485
Is the Data Provisional or Final?				Provisional	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	96.4	96.5	97	97.2	97.5

Notes - 2005

Due to reporting lag differences between the Newborn Hearing Screening Registry and the Nevada Birth Certificate database, it is possible to appear to have more than 100% of the live births screened. This data is adjusted by the State Biostatistician. Thus, it is estimated that 96.2% of infants received a hearing screening prior to hospital discharge.

a. Last Year's Accomplishments
FY 05: 96.5 % (See State Priority 5). Data for this measure is from state mandated hospital reporting (NRS 442.550) in a Bureau data base.

The Nevada State Legislature created a new law, effective July 1, 2001 that states that a licensed hospital in Nevada that provides services for maternity care and the care of newborn children and a licensed obstetric center shall not discharge a newborn child who was born in the facility until the newborn child has undergone a hearing screening for the detection of hearing loss, or has been referred for such a hearing screening. The requirement does not apply to a hospital in which fewer than 500 childbirths occur annually. A provider of hearing screenings must conduct the hearing screening. In addition, the hospital or obstetric center must coordinate appropriate follow-up services. Each licensed hospital and obstetric center shall annually prepare and submit to the Health Division a written report concerning hearing screenings of newborn children. The report must include the number of newborn children screened and the results of the screenings. A parent or guardian does have the option of declining the hearing screening of the newborn, as long as it is in writing.
The Health Division hired a contractor to work with providers to educate them on the benefits of newborn screening, identifying the reasons for and addressing refusals, and ensuring they have the information they need about follow-up, particularly early intervention and its benefits. A database was established to track infants who need follow-up and ensure it was done.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Nevada Newborn Hearing Screening program screens 96.5% of infants born in the State.			X	
2. Families with infants who were referred for further hearing evaluation post hospital discharge are contacted by letter and offered assistance.		X		
3. The Newborn Hearing Screening program works with Early Intervention Services to encourage follow up evaluation for hearing and speech and language developmental assessment.		X		
4. The Newborn Hearing Screening program works with CSHCN to offer families assistance with accessing needed services.	X			
5. The Newborn Hearing Screening program maintains a 'registry" of children who were referred for further hearing evaluation.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
A full time employee will be hired in the summer of 2006 to continue the hearing screening program activities. The backlog of referrals is now clear and letters were sent to all those families whose infant was referred for further evaluation. The contractor has been meeting with hospital staff and audiologists involved with hearing screenig to identify problem areas in the program. Providers have continued to provide data on a monthly basis, and the data is then put into a SHD database to track cases. Only hospitals delivering more than 500 babies per year are required to provide hearing screening for newborns prior to discharge.

Infants who "fail" the initial Newborn Hearing Screening are referred to their PCP and to the E.I. clinics for further evaluation. Families needing financial assistance are referred into the CSHCN program, which can cover the costs associated with surgery and/or hearing aides if needed. The infants continue to be seen and evaluated by E.I. staff to assure that the child meets appropriate developmental milestones. E.I. services transition the children into the school district special education program at 3 years of age, thus avoiding any break in service and assuring that the child achieves its maximum potential. This provided a "seamless" system of assistance to families.
The Health Division was awarded a continuation grant to expand the Newborn Hearing Screening Program and its capacity to collect enhanced follow up information from families, physicians and audiologists.
Problems still exist with gathering timely follow up data on infants referred for further evaluation. Families are not responding to the follow up letters, nor to a second follow up letter. E.I. clinics and staff are collaborating regarding case outcome information and doing increased cross referral. Private providers are refusing to provide any follow up data due to HIPAA concerns and are reluctant to commit to spending the time referring patients to the NBHS program. Staff secured an Attorney General opinion that states there is no HIPAA violation when reporting data on a state mandated program. Hopefully, this will improve our ability to collect follow up data. However, the contractor resigned after approximately six months, thus slowing the progress on these goals. The HD is in the process of hiring an FTE to fill this position and proceed with the plans in place.

Newborn Hearing program staff continue to meet the Real Choice Systems Change grant staff to share the results of the Newborn Hearing Screening needs assessment. Many of the issues identified are being addressed in the RCSC pilot projects and the RCSC grant is evaluating ways to improve the statewide infrastructure for the hearing impaired. Linkages with community groups involved with the hearing impaired were established to exchange ideas and identify funding sources to develop improved resources statewide.

c. Plan for the Coming Year
Plans are to continue to work with hospitals to enhance the quality and timeliness of data. Follow-back services will be enhanced to assure that all infants screened received appropriate follow-up treatment if indicated. Staff plan to contact all specialty ENT physicians and audiologists in the state and will advise them of the legal opinion from the Attorney General's office that clarifies HIPAA requirements and allows reporting of information for screening programs. Staff will continue to work with hospital staff and individual providers to enhance data quality and timeliness, as well as develop standardized protocols and procedures for referral. Plans are to link with Medicaid and Nevada Check Up data to improve the capacity to assure effective treatment in a timely fashion.

Legislation in place mandates an annual report to the Governor. However, as the program continues and improves, not only data collection/reporting will improve, but additional analysis will be provided on follow-up, enrollment in E.I. etc. This data will be available for use by the Nevada Advisory Council on CSHCN to utilize in making recommendations for improvements in services to CSHCN. Plans are to meet with hospital staff to work on improvements in data collection and analysis that will produce not only improved information for state agencies, but also for individual hospitals.

The bill that established an Office of Disabilities in the DHR Director's Office also established a committee on Deaf and Hard of Hearing. The RCSC team and the Nevada Advisory Council on CSHCN will work with this committee. The RCSC team will link the Office of Disabilities - Deaf and Hard of Hearing committee with the Nevada Advisory Council on CSHCN relative to sharing data from the hearing needs assessment, transition issues and recommendations made as a result of the RCSC needs assessment.

The brochure will be updated in both English and Spanish. It can be used by hospitals to advise families about the importance of hearing screening. Staff will continue to collaborate with hospitals to provide information to hospital personnel regarding the importance of newborn screening and follow-up. The database will continue to be used to track and follow infants that need further services. Bureau staff will also continue to advocate that the services of the Bureau of Early Intervention Services be utilized more.

State Performance Measure 6: *The percent of children and youth ages birth through aged 18 who died from unintentional injuries should be decreased.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			12.2	13.3	6.9
Numerator			76	85	46
Denominator			625350	641220	667831
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	5	5	5	5	5

a. Last Year's Accomplishments
SPM #6: The percent of children and youth ages birth through 18 who die from unintentional injuries should be decreased. FY 05: 6.89. (See State Priority 9).

The data for FY 05 for this state performance measure is from State vital statistics provided by the CHDR, Bureau of Health Planning and Statistics. This is preliminary data. This measure is a population-based measure that impacts children and youth from birth through age 18.

The Nevada State Health Division's Injury Prevention Task Force oversees Nevada's injury prevention initiative. Members of the task force include: representatives from the Department of Education, Nevada Department of Transportation, the SHD BLC Emergency Medical Services (EMS), Bureau of Health Planning and Statistics, Southern Nevada Health District, Washoe County District Health Department, SAFE KIDS Clark County, SAFE KIDS Washoe County, Indian Health Services, Nevada Office of Traffic Safety, and the Nevada Office of Traffic Safety. The Injury Prevention Task Force focuses on all age groups, including children and youth.

The Injury Prevention Program applied for and received funding through the Centers for Disease Control and Prevention to continue Nevada's Injury Prevention Program for five more years. The program will now be funded through July 31, 2010.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Injury Prevention Program will have a task force to provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.				X
2. The Injury Prevention Program will collaborate with the Washoe County SAFE KIDS Coalition. The Coalition is committed to the prevention of childhood injury in Northern Nevada.		X		

3. The Injury Prevention Program employs a full-time Biostatistician who is responsible for improving data collection and analysis of injuries in Nevada, including childhood injuries.				X
4. The Injury Prevention Program will seek funding sources to carry out public education campaigns to reduce unintentional injuries to children.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
SPM 6: FY 06.

The Injury Prevention Program is involved in the Child Passenger Safety Task Force, which is a result of a recommendation made in the Occupant Protection for Children Assessment, and is organized by the Nevada Office of Traffic Safety Office. The purpose of the Task Force is to provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.

The Injury Prevention Program is also involved in the Washoe County SAFE KIDS Coalition. The Coalition is committed to the prevention of childhood injury in Northern Nevada.

The Injury Prevention Program now employs a full-time Biostatistician who is responsible for improving data collection and analysis of injuries in Nevada, including childhood injuries.

The Injury Prevention Program applied for and received funding through the Centers for Disease Control and Prevention to continue Nevada's Injury Prevention Program for five more years. The program will now be funded through July 31, 2010.

c. Plan for the Coming Year
SPM 6: FY 07.

The Injury Prevention Program will continue its involvement in the Child Passenger Safety Task Force, which was a result of a recommendation made in the Occupant Protection for Children Assessment, and is organized by the Nevada Office of Traffic Safety Office. The purpose of the Task Force is to provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.

The Injury Prevention Program will continue its involvement in the Washoe County SAFE KIDS Coalition. The Coalition is committed to the prevention of childhood injury in Northern Nevada.

The Injury Prevention Program will continue to employ a full-time Biostatistician who is responsible for improving data collection and analysis of injuries in Nevada, including childhood injuries.

State Performance Measure 7: *Increase the ratio of primary care providers to the number of children and youth ages birth to twenty-one and women of child bearing age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					583.2
Numerator					1148967
Denominator					1970
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	600	610	625	650	675

a. Last Year's Accomplishments

SPM 7: FY 05: This is a new State Performance Measure. (See State Priority 1). It is indirectly related to last year's SPM 19: Homes for primary medical care, regardless of ability to pay, should be increased for children, youth, women of childbearing age, and CHSCN ages 0-19. This measure is also indirectly related to NPM 13: Percent of children without health insurance. Homes for primary medical care was interpreted to include persons who were covered by medical insurance. The most recent reliable estimate (February 2005) of Nevada children and youth ages birth to 21 and women of childbearing age (15-44) without health insurance was based on an "Uninsured Persons in Nevada" study conducted for Great Basin Primary Care Association in 2004. The total estimated number of children and youth ages 0-21 and women of childbearing age in 2005 was 1,148,967. The 2005 source of the estimate was the Health Division's Bureau of Health Planning and Statistics in conjunction with the State Demographer's Office. The estimated number of primary care providers in 2005 was 1,970. Primary care providers are defined to include the following practices: family practice, general practice, pediatrics, internal medicine, obstetrics, gynecology, and psychiatry. Primary care providers include MDs and DOs who have full-time practices in Nevada. The sources of the lists of primary care providers with active licenses in 2005 were the Board of Medical Examiners and the Board of Osteopathic Medicine. The ratio of primary care providers to the number of children and youth ages birth to 21 and women of childbearing age in 2005 was estimated at roughly 1:583.

Efforts to improve this measure are related to Infrastructure Services in terms of the Performance Measurement System. This measure also relates to priority 1, access to primary care.

Ongoing activities through the Bureau's Primary Care Development Center (see NPM 13) continued to contribute to improvement of the primary care safety net, which helped to increase access to and the availability of primary care providers throughout the state, most noticeably in medically underserved areas. PCDC activities included designating health professional shortage areas, placing NHSC and SEARCH providers in underserved areas, providing financial and technical support for community development activities related to primary care. Key partners for PCDC include Great Basin Primary Care Association, University of Nevada School of Medicine, Nevada Health Centers, Nevada Rural Hospital Partners, and the Office of Rural Health

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Support expansion of the Nevada Check Up Program to increase enrollment for children		X		
2. Improvement of the primary care safety net to promote access to care, particularly for the uninsured through the designation of HPSAs, MUPs, and MUPs, and financial and technical support for community development activities related to primary care.				X
3. Support public and private programs targeted to women and		X		

children that refer to Medicaid and Nevada Check up including WIC, CHSCN, the MCH Campaign, and the members of GBPCA.				
4. Address underserved problems which impact the availability of OB/GYN services to women of childbearing age and access to medical specialists for CSHCN. For example, place obstetricians in NHSC and SEARCH positions whenever possible.		X		
5. Support PCDC's recruitment activities through programs it administers such as the J1-Visa Waiver program and the National Health Service Corps.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

SPM 7: FY 06. Regarding primary care physicians (PCPs), it appears that the increase of new PCPs in FY 06 offset the increase in the population of the target groups. The total estimated number of children and youth ages 0-21 and women of childbearing age in 2006 was 1,176,150. The source of the estimate is the Health Division's Bureau of Health Planning and Statistics in conjunction with the State Demographer's Office. The estimated number of primary care providers in 2006 was 2,188. The ratio of primary care providers to the number of children and youth ages birth to 21 and women of childbearing age in 2005 was estimated at roughly 1:538. This represents an improvement in the ratio.

All of the BFHS programs and services that contributed to SPM 7 continued to be carried out in FY 06. BFHS activities targeted to women and children that contributed to this performance measure included CHSCN, the MCH Campaign, and WIC. The contribution of public and private programs targeted to women and children was also discussed in a preceding section concerning NPM 13. The most important efforts in FY 06 related to this measure involved three major ongoing activities:

1. Substantial increase in enrollment in the State Medicaid Office's Check Up program.
2. Public and private programs targeted to women and children; i.e. the MCH Campaign, WIC.
3. Improvement of the primary care safety net to promote access to care, particularly for the uninsured.

Ongoing activities through PCDC (see NPM 13) continued to promote improvement of the primary care safety net, which served to increase access to and the availability of primary care providers throughout the state, most noticeably in medically underserved communities. PCDC continued to provide financial and technical support for community development activities related to primary care such as the Washoe County Access to Healthcare Network and the Clark County Health Access Consortium.

c. Plan for the Coming Year

In FY 07 the Nevada Check Up program, which the Bureau actively supports, is expected to continue to increase enrollment and thereby reduce the number of uninsured children and youth. It is also anticipated that the gradual improvement in the economy will enable persons including the target groups of child bearing age to become insured. Having insurance coverage equates to having a medical home.

BFHS will continue to carry out its ongoing activities outlined above, all of which contribute to

helping offset the obstacles to care related to a lack of primary care providers for children and youth ages birth to 21 and women of childbearing age.

Through the programs it administers, PCDC will continue its efforts in FY 07 to enhance the primary care safety net as a significant approach to mitigating limitations to care related to lack of primary care providers. PCDC will continue to collaborate with its major partners in seeking to promote access to care for the medically underserved. In the two main population centers of Nevada, PCDC will continue to actively support the efforts of the Washoe County Access to Healthcare Network and the Clark County Health Access Consortium.

State Performance Measure 8: *The percent of women (18-44) who feel down or depressed should be decreased.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					55.1
Numerator					290954
Denominator					528047
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	30	30	29	28	28

Notes - 2005
The annual number here is the weighted percentage from BRFSS for all women ages 18-44 who answered feeling down or depressed at least 1 day during the last 30 days.

a. Last Year's Accomplishments
SPM # 8 a Percent of women (18 -- 44) who feel down or depressed should be decreased. (See State Priority 3).

FY 05: Past activities have been limited for this new state performance measure. The Nevada Legislature passed legislation increasing funding for suicide prevention activities. As a result, Nevada hired a State Suicide Prevention Coordinator and a Southern Nevada Suicide Prevention Trainer/Facilitator. They participated, along with providers and other interested individuals, in the 2005 Suicide Prevention Resource Center conference.
Multiple agencies have come together to coordinate efforts to address suicide. The Nevada State Health Division, Bureau of Family Health Services, is one of these agencies. There is a statewide toll-free suicide prevention hotline, and some Nevada based organizations have extensive websites with links to resources for those suffering with suicidal ideation.
In addition, the Bureau of Family Health Services contracted with obstetrical providers through the MCH Campapign. All providers screened for perinatal depression, and referred women as needed to appropriate services. The providers kept a list of services available in their area to discuss with the woman if needed.
The Health Division addressed other issues that may lead to depression, such as domestic violence, sexual violence, and chronic diseases.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Bureau staff will serve on the Suicide Prevention Coalition.			X	
2. Contract with direct health care providers to screen for perinatal depression.		X		
3. Continue with sexual assault prevention activities.			X	
4. Collaborate with Nevada Network Against Domestic Violence to provide training to health care providers.		X		
5. Inform, educate and empower the public about chronic disease prevention.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
SPM # 8 b

FY 06: Current activities to address this new state performance measure include continued collaboration with the State Suicide Prevention Coordinator and Southern Nevada Suicide Prevention Trainer/Facilitator. The Bureau is one of multiple agencies that have come together to coordinate efforts to address suicide.
There is a statewide toll-free suicide prevention hotline, and some Nevada based organizations have extensive websites with links to resources for those suffering with suicidal ideation.
In addition, the Bureau of Family Health Services continues to contract with obstetrical providers. All providers must screen for perinatal depression, and refer women as needed to appropriate services. The providers keep a list of services available in their area to discuss with the woman if needed.
The Health Division is addressing other issues that may lead to depression, such as domestic violence, sexual violence, and chronic diseases. The Bureau has a representative on the Attorney General's Domestic Violence Prevention Council. They just completed a needs assessment. The representative is also active on the Nevada Health Care Standards committee, which works to train health care providers to screen for domestic violence. At this time, they are working with nursing schools to have the curriculum integrated into their current curriculum.

c. Plan for the Coming Year
SPM # 8 c

FY 07: Future activities to address this new state performance measure include: Continued collaboration with the State Suicide Prevention Coordinator and Southern Nevada Suicide Prevention Trainer/Facilitator. The Bureau will also continue to attend the Suicide Prevention Coalition.
A statewide toll-free suicide prevention hotline will continue to operate, and some Nevada based organizations will continue to have extensive websites with links to resources for those suffering with suicidal ideation.
In addition, the Bureau of Family Health Services continues to contract with obstetrical providers. All providers must screen for perinatal depression, and refer women as needed to appropriate services. The providers keep a list of services available in their area to discuss with the woman if needed.
The Health Division will continue to address other issues that may lead to depression, such as domestic violence, sexual violence, and chronic diseases. The Bureau will continue to have a representative on the Attorney General's Domestic Violence Prevention Council.

E. Health Status Indicators

BG2006 IV E Health Status Indicators

The Bureau is directly charged with initiatives addressing Health Status Indicators 1A (percent of live births weighing less than 2500 grams), 1B (the percent of singleton births weighing less than 2500 grams), 2A (percent of live births weighing less than 1500 grams), and 2B (percent of live singleton births weighing less than 1500 grams) as well as 7A and 7B (Live births to women of all ages) enumerated by maternal age, race and ethnicity) through its MCH Campaign. Through these measures the effectives of initiatives addressing healthy birth outcomes are monitored. As discussed earlier in this document changes made with the dropping of the Medicaid asset test, the establishment of the MCH Campaign through approval by the 2005 Legislature, and the upcoming raising of the poverty level for coverage of prenatal care by Nevada Check Up to 185% FPL. are as yet unevaluated as they are too new to have produced any data. The data was used to identify the lack of success of Baby Your Baby and justify the development of the MCH Campaign. They are the reason the Division is going for a previously discussed enhancement for a best practices based initiative to address African American birth outcomes during the 2007 Legislative session. This request has the support of the Department.

The Bureau has an injury prevention grant funded by CDC that uses data such as that of 3A (the death rate per 100,000 due to unintentional injuries among children aged 14 years and younger), 3B (the death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes), 3C (the death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years), 4A (the rate per 100,00 of all nonfatal injuries among children aged 14 years and younger) 4B (the rate per 1000,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger), 4C (the rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years) and 8A and 8B (Deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race and ethnicity). It has a biostatistician who is charged with injury surveillance and an Injury Task Force charged with addressing injury in Nevada based on the data. The Injury Prevention initiative is described in National Performance Measure 10. Information on the Injury Prevention initiative may be found at http://health2k.state.nv.us/BFHS/injury. There 2 reports prepared under the biostatistician may be found, one on the use of surveillance in injury prevention and another a surveillance report on Nevada injuries. Preventing infant deaths is also a goal of the MCH Campaign.

The Bureau of Community Health (BCH) has the Sexually Transmitted Disease Prevention program and has supplied this data for 5A and 5 B, the rates of Chlamydia. They have initiatives that address adolescents and women of child bearing age, including the BCH Community Health Nursing which has Family Planning Grants and can do testing of STDs. (Community Health Nursing is also supported by the MCH BLock Grant). Adolescents at the Bureau's Adolescent Clinics in Las Vegas and Reno can get tested for STDs there.

The demographic data of 6A and 6b just emphasizes how Nevada continues to grow. The impact of growth has been noted in the Overview (III A) and throughout this document.

For 9A and 9B, Demographic Data, individual programs are under the governance of different portions of state government. The Bureau oversees WIC which as previously noted continues to experience growth, reaching over 50,000 participants a month in May of 2006. The Bureau partners with the Division of Health Care Financing and Policy, the Welfare Division, the Department of Education and others to get this data, and works with every one of them to promote the health and well being of Nevada's children. These partnerships are detailed throughout this document.

For HSI 10, 11 and 12, the Bureau watches the population and economic status of residents of the state in all its programs, from projecting potential WIC participants to identifying where to target outreach activities.

The Health Status Indicators are but a small portion of the data the Division collects through the Center for Health Data and Research. Data plays a clear role in soliciting grants, building programs, and evaluation through all Bureau programs.

F. Other Program Activities

As noted in III, E, State Agency Coordination, Early Intervention is now in the Bureau of Early Intervention Services (BEIS) in the SHD. Title V MCH Block Grant funds support these services. BEIS is collocated with the Bureau. Most of the Bureau's specialty clinics are held in BEIS facilities.

The Nevada WIC program piloted an Electronic Benefit Transfer (EBT) system for the provision of WIC benefits to participants in Washoe County starting in 2002. Nevada is now rolling out of WIC EBT in Las Vegas; EBT in Las Vegas should be accomplished by the end of 2006. The EBT card is a "smart" card which can ultimately contain other data such as a child's immunization record or participation in Head Start. With EBT participants can go to any WIC vendor who has EBT capability for their groceries, and only have to take what they need at the time. Vendors do not have to worry about out of compliance purchases that lead to vendor fines, as foods are accepted or rejected electronically and do not rely on the grocery clerk's knowledge of WIC. Vendors are reimbursed for the WIC purchases over night, in contrast to taking several weeks with paper vouchers.

All activities of Nevada MCH are included one way or the other in performance measures and are recorded within the National and State Performance Measures Sections. If they are not included, they are not addressed by Nevada MCH. This includes purchase of health insurance, and applied research, all listed in the Pyramid. As previously noted, WIC is part of MCH.

Nevada's has three toll-free hot-lines. The first and primary line is the MCH Campaign's 1-800-429-2669. In CY 2005 it had 1,131 calls. The second line is part of a WIC/Immunizations/Medicaid promotion. Its number is 1-800-8 NEV WIC. It is discussed under NPM 7. The third line started in FY 05 as the CSHCN line and is now being widely marketed as such. it is 1-866-254-3964. In 2005 it had 809 calls.

All three lines are widely marketed. They are all answered in the Bureau and are all bilingual, both English and Spanish. They are included in multi-media bilingual campaigns for the MCH Campaign, CSHCN and WIC. They will all be a part of the new 211 system approved by the 2005 Legislature in June 2005.

G. Technical Assistance

Nevada's priority for this year once again is technical assistance on dealing with health disparities. The disparity in African American birth outcomes in particular is alarming. Linking to successful initiatives that address health disparities would be very helpful. In FY 05 Clark County unsuccessfully applied for a Healthy Start Grant to address birth outcome disparities in African Americans. This is the third year assistance of this nature has been requested. The Bureau is partnering with the State's new Minority Health Officer to come up with a plan to address African American birth outcome disparities but there is much more that could be done.

We are particularly looking for John G. Reiss, PhD, Institue for Child Health Policy, to come out and help us with systems development for CSHCN, as a follow up to the activies of the CMS grant.

Nevada's cultural competency training for Bureau staff and others who work with MCH is a priority left over from prior years. Such training should be a follow-up to the training offered in 1999 through the National Center for Cultural Competency that was not very well received by staff. The Bureau has identified a Local source for the training at the University of Nevada Reno and is only awaiting word that technical assistance funds are available. In 2005 the Bureau is still awaiting word.

V. Budget Narrative

A. Expenditures

Form 3, State MCH Funding Profile shows FY 2005 MCH expenditures amounted to $1,849,339 with the appropriate expenditure match of state funds adhering to the required 3-4 match of three (3) state dollars for every four (4) federal dollars. The State expenditure amount was $1,380,995 for a total of $3,230,334. The MCH budget for FY 2005 was $3,643,062, so expenditures were $412,728 less than budget, or 11.3% of the budgeted amount. The expenditure variance is partially explained by holding the $150,000 amount as carry forward for expenditures in future years.
Other federal funds expended during FY 2005 amounted to $40,476,173. This compares with the budgeted amount of $39,489,037 to exceed budgeted expenditures by 2.5%. For FY 2005 the total budget under the guidance of the MCH Chief was $43,132,099 and expenditures under the guidance of the MCH Chief amounted to $43,706,507, which indicates additional grant funds of $574,408 were available for expenditures under the direction of the MCH Chief.

Form 4, Budget Details By Types of Individuals Served provides the detail for budget expenditure variances by population served. Pregnant Women included budgeted expenditures of $1,446,253 and actual expenditures amounted to $1,410,605 in FY 05. The budget expenditure variance for Pregnant Women is $35,648, or 2.5% below the amount budgeted. Expenditures for the Pregnant Women population included newborn screening expenditures. Federal expenditures for Pregnant Women amounted to $369,333, or 20.0% of federal funds expended in FY 2005.

Form 4 for FY 2005 for Children 1 to 22 Years Old included budgeted expenditures of $929,734 and actual expenditures amounted to $776,271. The budget variance for this group is a decrease of $153,463, or 16.5% below the amount budgeted. The budget variance is due to a transition of budgeting methodology from straight-line expenditures by population group to attempting a more accurate estimation of the amount expenditures will be in future years. The current methodology is based on percentage expenditures from the year of expenditures currently being reported. Federal expenditures for Children 1 to 22 Years Old amounted to $593,271, or 32.1% of federal funds expended in FY 2005.

Form 4 for FY 2005 for Children with Special Health Care Needs included budgeted expenditures of $1,067,472 and actual expenditures amounted to $845,328. The budget variance for this group is a decrease of $222,144, or 20.8% below the amount budgeted. The budget variance is due to a transition of budgeting methodology from straight-line expenditures by population group to attempting a more accurate estimation of the amount expenditures will be in future years. The current methodology is based on percentage expenditures from the year of expenditures currently being reported. Federal expenditures for Children with Special Health Care Needs amounted to $688,605, or 37.2% of federal funds expended in FY 2005.

Form 4 for FY 2005 for Administrative costs, included budgeted expenditures of $199,603 and actual expenditures amounted to $198,130. The budget variance for this group is a decrease of $1,473, or 0.7% below the amount budgeted. No budget variance explanation is needed for this group. The $198,130 was less than the 10% threshold for Administrative expenditures per grant guidance.

Form 5, State Title V Program Budget and Expenditures By Type of Service, Direct Health Care Services for FY 2005 included budgeted expenditures of $1,384,364 and actual expenditures amounted to $835,058. The budget variance for this group is a decrease of $549,306, or 39.7% below the amount budgeted. The budget variance is due to a transition of budgeting methodology from straight-line expenditures by population group to attempting a more accurate estimation of the amount expenditures will be in future years. The current methodology is based on percentage expenditures from the year of expenditures currently being reported. Federal

expenditures for Direct Health Care Services amounted to $489,169, or 26.5% of federal funds expended in FY 2005.

Form 5, State Title V Program Budget and Expenditures By Type of Service, Enabling Services for FY 2005 included budgeted expenditures of $837,904 and actual expenditures amounted to $626,057. The budget variance for this group is a decrease of $211,847, or 25.3% below the amount budgeted. The budget variance is due to a transition of budgeting methodology from straight-line expenditures by population group to attempting a more accurate estimation of the amount expenditures will be in future years. The current methodology is based on percentage expenditures from the year of expenditures currently being reported. Federal expenditures for Enabling Services amounted to $534,557, or 28.9% of federal funds expended in FY 2005.

Form 5, State Title V Program Budget and Expenditures By Type of Service, Population-Based Services for FY 2005 included budgeted expenditures of $1,109,191 and actual expenditures amounted to $1,357,401. The budget variance for this group is an increase of $248,210, or 22.4% above the amount budgeted. The budget variance is due to a transition of budgeting methodology from straight-line expenditures by population group to attempting a more accurate estimation of the amount expenditures will be in future years. The current methodology is based on percentage expenditures from the year of expenditures currently being reported. Federal expenditures for Population-Based Services amounted to $413,795, or 22.4% of federal funds expended in FY 2005.

Form 5, State Title V Program Budget and Expenditures By Type of Service, Infrastructure Building Services for FY 2005 included budgeted expenditures of $311,603 and actual expenditures amounted to $411,818. The budget variance for this group is an increase of $100,215, or 32.2% above the amount budgeted. The budget variance is due to a transition of budgeting methodology from straight-line expenditures by population group to attempting a more accurate estimation of the amount expenditures will be in future years. The current methodology is based on percentage expenditures from the year of expenditures currently being reported. Federal expenditures for Infrastructure Building Services amounted to $411,818, or 22.3% of federal funds expended in FY 2005.

B. Budget

This FY 2007 MCH application budget adheres to the required 3-4 match of three (3) state dollars for every four (4) federal dollars. The federal MCH portion is estimated, for budget planning purposes at $2,126,405 and is based upon $1,976,405 in FY 07 allocation and an anticipated carryover of $150,000 from the FY 06 allocation. The state MCH match, budgeted at $1,482,304 is comprised of State General Fund dollars and fees generated by the Newborn Screening program. The state MCH is for the current year allocation as the state match for the carryover was expended during the current fiscal year. The total FY 07 MCH budget is $3,608,709. As required, the FY 07 MCH budget complies with the FY 89 Maintenance of Effort amount. This amount represents $853,034.

For FY 07, 30.0% of the federal Title V allocation is directed to Section 1 of Form 2,Component A, Preventive and primary care for children and adolescents that amounts to $592,922. Direct services provided under Component A are primary care and oral health oriented, as these represent two significant unmet needs for children and adolescents. Services are provided through community based non-profit agencies, as well as through the health districts in Clark County and Washoe County. In addition to direct services, Component A includes funding for the continued development of core public health/infrastructure activities including oral health and teen pregnancy prevention to ensure appropriate and continued services to children and adolescents.

For FY 07, 30.0% of the federal Title V allotment is directed towards Children with Special Health Care Needs, Section 1, Form 2, Component B. The allotment budgeted for Component B

services amounts to $592,922. The individuals to be served under Component B are children with special health care needs and their families. Services funded under this component are primarily enabling services and are designed to be family-centered, community based, culturally appropriate and comprehensive. Direct services are provided through several mechanisms: through the Nevada Early Intervention Services and through health professionals, such as pediatric ophthalmologists and physical therapists who are under contract to the CSHCN program and the CSHCN treatment program. In FY 06 all these services are provided through the Nevada Early Intervention Services in Reno and Las Vegas and CSHCN staff based in Carson City. They will also support the pilot projects for CSHCN systems of care in Nevada that will be developed by the Real Choice Systems Change grant project.

For FY 07, Administrative costs, Section 1, Form 2, Component C will not exceed $197,640, which is 10% of the current period grant request total. For FY 07, the remaining federal Title V allotment is directed towards services for pregnant women and postpartum women and infants up to age 1 year. The allotment budgeted for services is $592,921. The individuals to be served are pregnant and postpartum women and infants up to age 1 year statewide. Services are designed to be family-centered, community based, culturally appropriate and comprehensive. Direct services are provided through contracts with local agencies, including health districts and community based non-profit agencies. In addition, funding includes the continued development of core public health/infrastructure activities. The integration of perinatal substance abuse services including prevention of fetal alcohol syndrome into routine perinatal services received by all pregnant women is an example of the core public health activities to be continued in FY 07. A newly proposed breastfeeding initiative of the American Academy of Pediatrics will be supported through this component. Also included is the State's Newborn Screening program, which screens almost every infant born in the state for inborn errors of metabolism and hemoglobinopathies. The mandated newborn hearing screening passed during the State's 2002 Legislature (those born at hospitals with over 500 births) will be part of the program. Follow-up for the identified children is included in Component B.

Overall, allocation of MCH dollars across Components A, B, & C is based upon unmet health care needs identified in the Year 2000 Five Year MCH Needs Assessment. The state assures a fair and equitable method of distributing funds based upon identified needs.

Nevada's MCH unexpended grant balance, as reported in last year's application, was basically expended as planned over the current 2005-2006 biennium. The goal was to leave approximately $150,000 in unexpended grant balance at the end of the upcoming biennium and this goal was met in FY 05. Nevada's Title V Maternal and Child Health Block grant has been fully budgeted through the Legislative process for the 2006-2007 biennium.

Other federal funds administered by the MCH Chief besides the Maternal and Child Health Title V Block Grant Program include a United States Department of Agriculture (USDA) grant for the state WIC program; Abstinence-Only Education, and State Systems Development Initiative grants funded by MCHB; Oral Health, Rape Prevention and Education, and Injury Prevention grants from CDC; Sexual Assault Prevention from PHHS, Real Choice Systems Change from CMS and Primary Care and NSHC SEARCH Program from the Bureau of Primary Health Care. Other federal grants include Early Childhood Comprehensive Systems, Newborn Hearing Screening and Children's Oral Health that provide different services to the populations served by the Maternal and Child Health Block Grant Program in accordance with approved grant proposals.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.